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ABSTRACT

The Phoenix, Arizona Early Head Start (EHS) program is for first-time teen parents and their families. The 1998-99 project year marked the fourth year of a 5-year research and demonstration grant for EHS and concluded the third full year of program implementation. This report analyzes Year Four program services and outcomes for children, families, and staff. The report also examines the program's community linkages and efforts to build community capacity to serve very young children and their families. Evaluation findings suggest that at the end of the 1998-99 project year, EHS continues to be on the right track. An array of direct services are in place to assist program families; an expanded staff training agenda on child development is helping family support specialists in their work with parents and children; and a range of community linkages and partnerships are helping to expand resources and options for families. Some areas continue to warrant attention, however. These include: helping young parents as their children become toddlers; defining and clearly articulating the rules and regulations guiding the transition of families out of the EHS program; developing ways to retain long-term staff members and better orient new employees; and conveying EHS knowledge and experience (and its relevance to public policy) to state and local decision-makers in a way that is both accessible and understandable to them. (Contains 18 references.) (EV)

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On Track with Phoenix Early Head Start

1998-99 Evaluation Report

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On Track with Phoenix Early Head Start

1998-99
Evaluation Report

by
Linda Sandler
and
Rick Heffernon

with assistance from
Kim Malone

Submitted to:
Southwest Human Development

February 2000

Phoenix Early Head Start is funded under a grant to Southwest Human Development, Inc. from the Administration for Children, Youth, and Families, U.S. Department of Health and Human Services. This research was conducted by Morrison Institute under a contract with Southwest Human Development, Inc., Phoenix, Arizona.

Phoenix Early Head Start

Executive Summary

Phoenix Early Head Start (EHS) is a program for first-time teen parents and their families. The 1998-99 project year marked the fourth year of a five-year research and demonstration grant for EHS and concluded the third full year of program implementation. The program was originally funded in 1995 by the Administration for Children, Youth, and Families as part of a national initiative to provide services for low-income pregnant women and families with children ages birth to three. Early Head Start is a family-centered program that is intended to provide early, continuous, intensive, and comprehensive child development and family support services for vulnerable families and their very young children.

Phoenix Early Head Start is operated by Southwest Human Development (SWHD), a non-profit human services organization providing comprehensive services to young children and families who are at-risk or have special needs. Southwest Human Development contracted with the Morrison Institute for Public Policy at Arizona State University to conduct a formative, continuous improvement program evaluation to assist Phoenix Early Head Start in refining program practices on an ongoing basis.

A description and analysis of the program's structure and planning phase during Year One, and detailed program descriptions, methodology, and research findings from Years Two and Three, are available in previous project evaluation reports (Sandler & Heffernon, 1999; Sandler & Heffernon, 1998; Sandler & Kleinschmidt, 1996). The current report analyzes Year Four program services and outcomes for children, families, and staff. It also examines the program's community linkages and efforts to build community capacity to serve very young children and their families.

Program Description

Phoenix Early Head Start recruits low-income teens ages 13 to 19 in central/south Phoenix who are pregnant with their first child or who have an infant under six months of age. Staff operate out of two program sites: 1) Hamilton Elementary School in west Phoenix, and 2) the Southwest Human Development Good Fit Center in central Phoenix. The program is designed to assist 120 families with services provided through a three-pronged approach: weekly home visits, site-based socialization and support activities, and "brokered" services that link families with high-quality community resources. Male involvement is also a major EHS program focus, with concentrated outreach efforts to engage young fathers with their children.

Program services are delivered by a primary staff of 12 family support specialists, guided by two site supervisors and overseen by a full-time project manager. These services are supported and enhanced by a resource staff that includes a family services manager, male involvement specialist, registered nurses, child development/disabilities specialists, mental health professionals, and a nutritionist. Transportation services are provided by a full-time van driver and part-time bus driver. Program components are designed to address the four original national Early Head Start cornerstones —child development, family development, staff development, and community building.

Child development is supported through ongoing home visits by the family support specialists, weekly parent-child play groups that promote positive parent-child interactions, and monthly site-based socialization activities focused on child development

topics. Additional support is provided by the child development/disabilities specialists, who facilitate play groups, consult with families and staff, administer developmental assessments, and coordinate services for children with special needs. Positive child outcomes are also advanced through the nurses, who assess children's developmental and physical progress during periodic home visits, facilitate health-related site-based activities, and consult with families and staff.

Family development services are coordinated by the family support specialists, who develop supportive relationships with parents to assist them in achieving their goals. Many families also receive services from the male involvement specialist, who helps engage fathers in the lives of their children. Additional services for families are provided by the family services manager and other resource staff.

Staff development is accomplished through a multi-disciplinary training approach designed to assist staff in working towards desired program outcomes. Training is provided by outside trainers and EHS resource staff, and through participation at national workshops and conferences. An expanded child development training agenda was implemented in 1998-99 with a range of training activities, including: monthly videotape reviews, monthly "brown-bag" lunch/workshops on child development, quarterly child development training sessions, more frequent interaction with the child development specialists, and training in developmentally-based curricula.

Community building is pursued on two levels: programmatically by linking and collaborating with other agencies to expand the breadth of services for young families, and on a broader level by increasing overall community capacity to serve young families and move the "birth to three" policy agenda forward. Program efforts generate linkages (e.g., with Crisis Nursery to offer EHS parents a quality child care option), and foster collaborations (e.g., the Young Fathers Network, a group of programs serving young fathers citywide). In addition, administrative level activities encourage broader-based coalitions, such as a SWHD agency partnership to develop a public-private model to support families and their children birth to three.

Program Outcomes

The continuous improvement program evaluation of Phoenix Early Head Start is designed to answer questions about program services, child development, family development, and staff development. It also examines progress towards the program's desired community outcomes and policy outcomes of local interest. The evaluation provides EHS managers and administrators with ongoing feedback that helps them analyze program outcomes and enables them to make adjustments as the program evolves.

Children and Families

Child and family development issues continued to be the predominant focus during home visits in 1998-99; additional assistance for children and parents was provided through parent-child play groups, site-based activities, and parent support groups. Program services appear to be having a positive impact, with most indicators suggesting improvement in parent knowledge of child development, parent-child relationships, and family development. Most EHS children continue to live in nurturing and supportive home environments, and several families exhibited improvements in their home environment over the course of the year. Many parents have gained knowledge about raising infants and toddlers, and they are engaging in higher quality interactions with their children. Some parents, however, continue to have difficulty dealing with their children's transition from infant to toddler. Despite their increased knowledge of raising a child, some parents continue to hold developmentally inappropriate expectations for their toddlers and use inappropriate strategies to address noncompliant behavior.

Many parents have maintained relatively positive mental health, despite continuing life stressors. Parent self-reports indicate that they have continued to employ a moderate level of coping skills over time, with some increase in higher level coping strategies; their stress related to parenting has experienced a small decrease over time, and continues to be low to moderate overall; their sense of self-efficacy has grown; and, their self-esteem has steadily increased over time. Mental health concerns might, however, surface for one group of parents. Some mothers who had second pregnancies reported setbacks in their

self-esteem and interruptions in their progress towards personal goals.

Personal health care practices and efforts towards self-sufficiency have also shown signs of progress. A large majority of EHS parents reported using birth control consistently; more parents are practicing appropriate health prevention and treatment for themselves and their children; and, more are utilizing appropriate safety practices. Many parents indicated progress towards self-sufficiency by holding jobs or attending school or training programs, and several reported graduating or completing a program. There are, however, some remaining areas of concern. A large number of parents who enrolled in education or training programs did not complete them, and literacy levels for many parents remain low. And with regard to health, some parents still did not get prenatal or postnatal care, and several families do not have a regular source of health care (*i.e.*, a "medical home").

Staff Development

Phoenix Early Head Start implemented an expanded training agenda and adopted a child development curriculum, providing staff with more focused, hands-on training on child development and parent-child relationships. Staff felt the new training focus was helpful and responsive to their needs; however, outcomes of the training were mixed. While knowledge in these areas has improved and staff demonstrated higher-level understanding of some concepts, a number of concepts continue to elude them. Many of the results of staff training data reflect the continuing impact of staff turnover; staff who had been employed longer (and thus received more training) generally registered higher scores than their less experienced and less trained colleagues on both objective and subjective measures. The intensified emphasis on child development also resulted in other training areas receiving less attention. And while most indicators suggest that staff are continuing to work well with their families, some staff expressed the need for more training on understanding adolescents.

Community Building

As with any long-term, multi-faceted program, EHS has experienced fluctuating levels of community connections and an ebb and flow of relationships over time. The program has maintained strong partnerships with the City of Phoenix Step-Up program and other young father programs; solid connections with the state's Developmental Disabilities Division, Early Intervention Program, and Division for Child Support Enforcement; and ongoing linkages with a wide range of community-based organizations. At the same time, relationships with education and child care resources (*e.g.*, the Village charter school for teen parents) have fluctuated. In general, most program stakeholders felt that only limited progress had been made in terms of the *evolvement* of linkages and collaboration during the 1998-99 program year. However, program administrators expect new linkages and activities to move things forward in the coming year, particularly in the areas of education and child care. These include a revitalized relationship with the Phoenix Union High School District, renewed activities with the Village charter school, and alliances with Crisis Nursery and the Osborn School District.

Administrative level activities have continued to focus on broader-based coalitions such as the "Smart Beginnings" SWHD agency partnership that resulted in the development of a public-private model to support families and their children birth to three. And, Phoenix Early Head Start has begun to lay groundwork for longer-term community change, building on its knowledge and experiences in three areas: 1) strategies to enhance the breadth and scope of male involvement programs throughout the community; 2) relevant training strategies for staff who work with children birth to three and their families; and, 3) community policies and services necessary to help teen parents succeed.

Summary

At the end of the 1998-99 project year, Phoenix Early Head Start continues to be on the right track. An array of direct services are in place to assist program families, an expanded staff training agenda on child development is helping family support specialists in their work with parents and children, and a range of community linkages and partnerships are helping expand resources and options for families.

As the program enters the final year of its current five-year program cycle some areas continue to warrant attention. These include: helping young parents as their children become toddlers; defining and clearly articulating the rules and regulations guiding the transition of families out of the EHS program; developing ways to retain long-term staff members and better orient new employees; and, conveying EHS knowledge and experience (and its relevance to public policy) to state and local decision-makers in a way that is both accessible and understandable to them.

Recommendations

The following recommendations are offered based on evaluation data gathered during the 1998-99 program year.

- Fortify strategies for helping parents understand and nurture their toddlers.
- Develop clear policies and practices for program transition.
- Improve orientation procedures for new EHS staff, and establish mechanisms for retaining and rewarding long-term staff.
- Implement solid strategies for communicating EHS knowledge and experience—and their implications for future public policy—to state and local decision-makers.

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Acknowledgments

The Phoenix Early Head Start continuous program improvement evaluation is a partnership between evaluators and program stakeholders. As partners in this evaluation, EHS staff and managers have taken on additional duties. Staff have been asked to serve as data collectors in addition to performing their direct service tasks. Program supervisors, managers, and administrators have been encouraged to rethink—and sometimes reconstruct—aspects of the original program plan and components. Data managers have been asked to convert information collected for program purposes into data suitable to answer evaluation questions. This has not been easy work.

To all of our EHS/SWHD partners—thank you. Our utmost thanks go to the family support specialists. Thanks also to Janice Mohr and Tina Wiggins-Sykes for helping shepherd the ongoing data collection process. Thank you, Gloria Tufo and Kevin Vaughan-Brubaker, for hanging in there with all the data challenges. And thank you, EHS parents, for sharing your thoughts with us. Finally, sincere thanks go to Sandy Foreman and Jan Martner for being strong collaborative partners in this endeavor.

The contributions of our colleagues at Arizona State University and Morrison Institute are also greatly appreciated. Bob Weigand, Director of the Arizona State University Child Study Laboratories, continues to play a pivotal role in informing and supporting key aspects of the evaluation. Celeste Minzikah's translating skills once again contributed to the success of the interview and focus group process for Spanish-speaking parents. And as always, our thanks to Cherylene Schick for designing and producing this report.

Introduction

Phoenix Early Head Start (EHS) is a program for first-time teen parents and their families. It was originally funded in 1995 by the Administration for Children, Youth, and Families as part of a national initiative to provide services for low-income pregnant women and families with children ages birth to three. EHS is a family-centered program that is intended to provide early, continuous, intensive, and comprehensive child development and family support services for vulnerable families and their very young children.

The EHS program recruits low-income teens ages 13 to 19 in central/south Phoenix who are pregnant with their first child or who have an infant under six months of age. Staff operate out of two program sites: 1) Hamilton Elementary School in west Phoenix, and 2) the Southwest Human Development Good Fit Center in central Phoenix. The program is designed to assist 120 families with services provided through a three-pronged approach: weekly home visits, site-based socialization and support activities, and "brokered" services that link families with high-quality community resources. Male involvement is also a major EHS program focus, with concentrated outreach efforts to engage young fathers with their children.

Program services are delivered by a primary staff of 12 family support specialists, guided by two site supervisors and overseen by a full-time project manager. These services are supported and enhanced by a resource staff that includes a family services manager, male involvement specialist, registered nurses, child development/disabilities specialists, mental health professionals, and a nutritionist. Transportation services are provided by a full-time van driver and part-time bus driver.

The 1998-99 project year (October '98-September '99) marked the fourth year of a five-year research and demonstration grant for Phoenix Early Head Start and concluded the third full year of program implementation. A detailed description and analysis of the program's structure and planning phase during Year One, as well as detailed program descriptions, methodology, and research findings from Years Two and Three, can be found in previous project evaluation reports (Sandler & Heffernon, 1999; Sandler & Heffernon, 1998; Sandler & Kleinschmidt, 1996).

This report analyzes Year Four program services and outcomes for children, families, and staff. It also examines progress towards the program's desired community outcomes, including efforts to build community capacity to serve young children and families. While foremost a child and family development program, Phoenix Early Head Start also embraces the community-building philosophy that is underscored in the national Early Head Start initiative, and which recognizes the importance of creating a community environment that supports very young children and their families.

■ ■ ■

Methods

Southwest Human Development contracted with the Morrison Institute for Public Policy at Arizona State University to conduct a continuous improvement evaluation of the Phoenix Early Head Start program. The purpose of this evaluation is to provide EHS managers and administrators with ongoing feedback that helps them analyze program processes and outcomes in a timely fashion, thus enabling them to make adjustments as the program evolves. The evaluation is designed to answer questions about program services, child development, family development, staff development, and community building. (See Appendix A for the complete evaluation design).

Instruments and Data Collection

Both qualitative and quantitative data sets are included in the evaluation, with a large part of the data collection being carried out by program staff. Some child and family assessment data are used both programmatically and evaluatively. Data for parents and children come from a number of sources. Parents are assessed at program enrollment and at subsequent six-month intervals, using assessment batteries composed of several different instruments (Appendix B presents a brief summary of each instrument). Annual parent surveys and focus group discussions provide information about program implementation. Case studies ("Family Stories") follow 12 families throughout their tenure in EHS. Child screening and assessment instruments monitor the progress of individual children as they progress through the program.

Evaluation of the staff training component of EHS incorporates a variety of approaches. Annual video-clip analysis appraises the ability of staff members to implement what they've learned with families. Focus groups, staff and supervisor surveys, and staff self-assessments provide a variety of information about staff training efforts. Annual interviews with key stakeholders and ongoing evaluator observations of program meetings and activities supply insights about overall program process and implementation.

Program Participants

The participants included in this study consist of 196 teen parents (194 mothers; 2 fathers) who were enrolled in EHS prior to September 30, 1999 and identified as primary caregivers.[1] Evaluation data are reported for this group of participants and their firstborn child (the "focus child"). Because fathers are also encouraged to become involved with their children and take part in program activities, participation data for fathers (e.g., site-based activities, "Dad's Night Out" activities, and father-child activities) are included when appropriate and noted in this report.

While EHS is designed to serve 120 families, the number of participants enrolled at any one time varies. Participants leave the program for many reasons (participant disenrollment is addressed later in this section), and replacement of families is ongoing. Analyses for this evaluation include all participants for whom data were available, whether or not the participant subsequently disenrolled. Because data reporting can be affected by a number of factors—families cycle in and out of EHS, parent assessments take place based on a participant's time in the program, parents sometimes miss an assessment occasion—the data sets available for individual analyses vary in size. Readers, therefore, are cautioned against "over-attributing" results of individual data analyses contained in the report.

[1] A total of 224 participants have actually been enrolled in EHS since the program's inception. The 196 study participants are those people for whom both participation and assessment data are available. Demographic and enrollment data are reported for this group. The number of participants included in individual trend analyses varies, however, depending on the number of people for whom "matched" data are available at any two specific assessment points.

Demographic and background information is provided by participants at program enrollment. Since many EHS participants are living at home with *their* parents and siblings, the information that follows for participants' families refers to this extended family unit when appropriate.

When they enrolled in Phoenix Early Head Start, participants were between 13 and 19 years-old. More than half the parents (52 percent) were 16 or 17 years old at enrollment, and more than 20 percent were 15 years or younger. At enrollment, eight percent of participants (16 people) were married; 92 percent were single. Nearly 62 percent of the parents described themselves as Mexican/Chicano, and almost 21 percent considered themselves black. The remainder of participants were reported as eight percent white, six percent biracial/multiracial, and three percent American Indian, Central American, or Vietnamese. English was the primary language reported to be spoken in 44 percent of homes, and Spanish was identified as the primary language in 29 percent of the homes. Another 27 percent of participants said both languages were spoken in their homes, while less than one percent specified some "other" primary language (Figures 1-3).

When they entered EHS, the most common source of public assistance reported by parents was the WIC program (Women, Infants, and Children), with 70 percent of families enrolled. More than half of all parents (61 percent) also indicated that their families received medical financial assistance such as AHCCCS or Medicare. In addition, 27 percent of families reported they were receiving food stamps at program enrollment, 22 percent were receiving TANF (Temporary Assistance to Needy Families), and 18 percent were receiving SSI (Supplemental Security Income) (Figure 4).

Figure 1

Parent Age at Enrollment

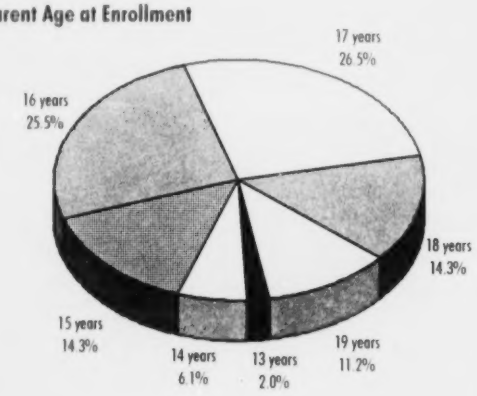

Figure 2

Parent Ethnicity

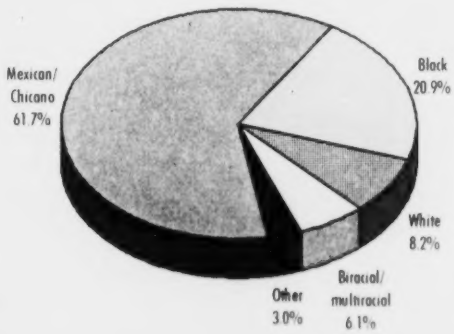

Figure 3

Language Spoken at Home

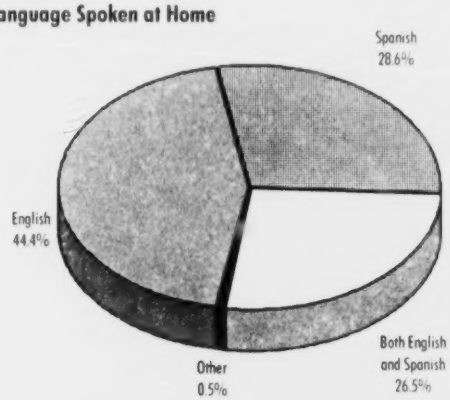

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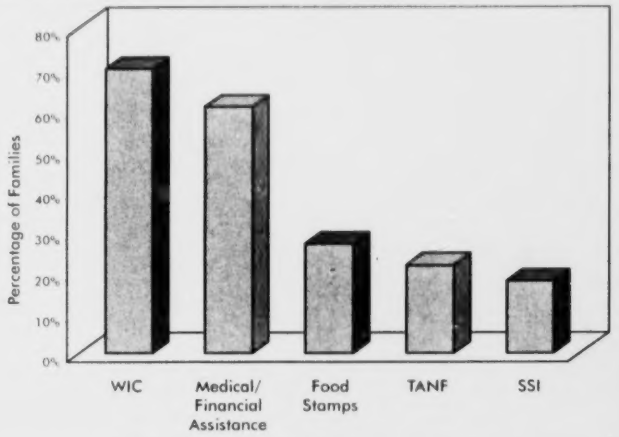
Figure 4

Public Assistance Snapshot: Family Status at Enrollment*



*Includes participants and the family members with whom they live (*e.g., their* parents)

At the time of enrollment, participants were also asked to appraise their family circumstances by rating the adequacy of their resources to meet 21 basic needs such as housing, medical care, and transportation. Participants reported an average of three areas each for which their family did not have adequate resources, with a range from 0 to 17. The five problems cited most frequently are listed in Table 1.

Table 1

Percentage of Families with Inadequate Resources: Top Five Problems

Area of Need	% of Families
Dental care for family	34.9%
Job for self or spouse/partner	32.0%
Opportunities to participate in community groups	27.3%
Dependable transportation	23.0%
Medical care	19.8%

Participant Disenrollment

Over the past three years Phoenix Early Head Start has experienced considerable participant turnover. By the end of the 1998-99 year, 15 percent of parents (29 people) had exited the program for "favorable" reasons (*i.e.*, they met their goals and no longer needed or had time for program services; and/or their children turned three and were referred to another early childhood program). Thirty-five percent of parents either asked to be disenrolled or were disenrolled because they were not participating in the basic program services (*e.g.*, they continually missed home visits). Still other families were disenrolled because they moved out of the program service area (7 percent), Child Protective Services removed the child from the home (2 percent), or for "other" reasons (1 percent). In all, 60 percent of the participants (118 people) included in this study had disenrolled from the program by September 30, 1999 (*i.e.*, they left the program some time during the last three years).

The turnover of families during the course of the past three years has been considerable, but it has not resulted in substantial changes in the overall demographic profile of EHS program participants. For example, the distribution of parents' age and ethnic background has remained similar across all three years. A noticeable shift did occur, however, in the primary language spoken at home. The percentage of EHS parents who live in homes in which they identified Spanish as the primary language steadily decreased, from 42 percent in 1996-97 to 29 percent in 1998-99. This was offset by a comparable increase in the percentage of homes in which both English and Spanish are spoken, from 14 percent in 1996-97 to 27 percent in 1998-99.

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Family Services and Outcomes

Services for Phoenix Early Head Start families are designed to support parents in their role as their children's primary caregiver, help them become self-sufficient, and move them towards economic stability. Family services are coordinated by family support specialists, who develop supportive alliances with parents to assist them in attaining their goals. Many families also receive services through the male involvement specialist, who helps engage fathers in the program and in the lives of their children. Additional services are provided by EHS resource staff.

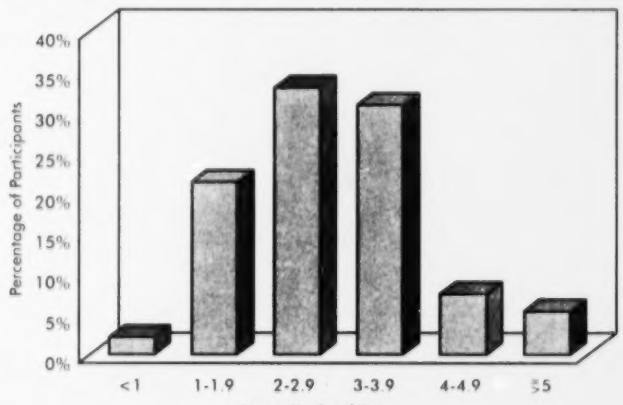
Multiple program activities are integrated to address the comprehensive goals and desired outcomes for EHS families. Family support services are delivered primarily through home visits and reinforced through monthly site-based events that combine socialization and educational activities, parent-child play groups, parent support groups, and parent committees and councils. The EHS family services manager coordinates, plans, and monitors the specific details necessary to support these activities.

Each family works with their family support specialist to develop a "family partnership agreement" (FPA) which helps them assess their individual strengths and needs. The FPA then serves as a guide to help each family work towards achieving their identified goals. A family's progress is followed through multi-disciplinary team (MDT) reviews conducted every six months. This process forms the basis for ongoing planning by bringing together family support specialists, resource staff, and program supervisors to assess a family's status.

The central program intervention strategy to support families is ongoing home visits. On average, EHS staff visited families 2.8 times per month during the 1998-99 program year, with the average number of visits per month to individual families ranging from less than one to eight (Figure 5).[2] The extent of services to each family varied, however, since families have different needs and demonstrate different levels of "compliance" or willingness to participate in program activities. The degree or "intensity" of

Figure 5

Average Number of Visits Per Family Per Month: 1998-99



[2] This number is based on participants who were enrolled in EHS at the end of the 1998-99 program year (i.e., on September 30, 1999) and those who left the program during the year for one of the following reasons: a) the family met their goals; b) the child was age eligible to transition to a preschool/Head Start setting. Participants who were disenrolled from the program during the year for other reasons were excluded from this calculation, since these parents have often been "missing in action" for several months prior to their disenrollment – during which time they would register *no* visits.

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service delivery also varied for different categories of services that are addressed during a family's home visits. The greatest focus of home visits continues to be on child and family development, with 57 percent of the issues discussed during visits related to these two areas. The proportion of each visit devoted to each of the major program service categories (child and family development, education and employment, medical issues, social services, child care, and emergency services) are specified in Table 2.

Table 2

Percentage of Contacts*
by Service Category per Visit: 1998-99

Service Category	% of Contacts Addressing These Issues
Child and family development	57.2%
Education and employment	15.9%
Medical	12.9%
Social services	8.1%
Child care	5.1%
Emergency	0.8%

*Percentage of time these issues were addressed

Note: Each service category includes several topics/issues. Therefore, each category can be addressed more than once during the same visit.

While ongoing home visits form the central EHS program intervention strategy, parents are also encouraged to participate in group activities, including site-based socialization activities and parent support groups. Providing social support as well as information related to parenting, health, child care, education, and employment, the socialization activities are an important EHS program component. Overall, 85 percent of the mothers enrolled in the program during the last year participated in at least one socialization activity in 1998-99. The average number of socialization activities attended by participants was four, with individual attendance ranging from 1 to 13 activities. Similar to the 1997-98 program year, a "core group" of participants attended the activities on a fairly regular basis. During the past year, this core group of 15 percent of participating parents attended seven or more socialization activities. At the other end of the spectrum, 43 percent of participants attended only one activity.

Parent support groups provide participants with an outlet for sharing personal concerns and a safe environment in which to exchange ideas with other parents. Overall, nearly 30 percent of the parents enrolled in EHS during the past year participated in at least one parent support group session. These participants averaged 9.5 sessions during the year, with individual attendance ranging from 1 to 26 sessions. As with the socialization activities, a core group of 30 percent of these mothers participated in the support groups with some regularity, attending 14 or more sessions during the year.

Additional information about the parent support group came from the parent focus groups. Nearly all the mothers articulated very positive feelings about these sessions. Many of the comments reflected the feeling of one mother who said: "How do I explain?...My child is, well ill... At my house I don't talk with anybody...nobody ever asks me anything. And so I come here and talk about everything—everything that happens to me. If I go to the doctor, or [want to talk about] something sad, I come and talk about it.... They make me feel better. I feel better talking with people here than at home." Other parents said they felt the support group helps with almost everything, and they agreed with one parent's comment that it "provides you with resources, not negativity."

Parents have the opportunity to develop their leadership skills when they participate on the EHS parent committee or the larger SWHD Head Start Policy Council. This year, two EHS parents were elected to the positions of chairperson and vice-chairperson for the Policy Council. Some program participants also increase confidence and communication skills by teaming with staff members to make presentations regarding EHS at local and national conferences (e.g., a local infant mental health conference, the Head Start Region IX meeting, and the national Zero to Three conference in Washington, DC). Parents who participated in these events expressed feelings of empowerment—"We 'ruled' at those conferences," one remarked.

EHS staff, however, noted that some of these parents had not been complying with other aspects of the program, such as showing up for home visits or attending school. They questioned whether such parents should be rewarded with leadership roles.

Male involvement remains a major focus of the EHS intervention, with the desired goal of engaging more fathers in the program and in the lives of their children. Forty-seven fathers participated in at least one home visit, with the number of home visits for individual fathers ranging from 1 to 20. This group of fathers averaged five home visits during the year. In addition, 30 fathers participated in other program activities. One-third of this group of fathers attended periodic "Dad's Night Out" events, while 22 fathers (73 percent of the group) attended at least one monthly site-based socialization activity.

While more fathers have been engaging in EHS and in their children's lives, staff remained concerned about the integration of the male involvement component within the program. Two main issues surfaced: first, whether the focus of father-related activities should be shifted more toward the key program goal of building father-child relationships, rather than on social activities; and second, the need for better communication regarding the expected level of engagement between the male involvement specialist and individual families. A third issue arose regarding new employee orientation: staff felt that newly hired family support specialists needed better briefing on the elements of the male involvement program and how best to work with it.

Adult-Child Relationships

One of Phoenix Early Head Start's primary goals is to help parents recognize and understand the developmental stages their children are going through and to respond to their needs in appropriate ways. Thus, program services are intended to help EHS parents form realistic expectations for their children's behavior and use effective parenting skills within that framework. Parent progress in developing positive relationships with their children was followed using instruments adapted from the national Early Head Start evaluation and by using locally developed measures.

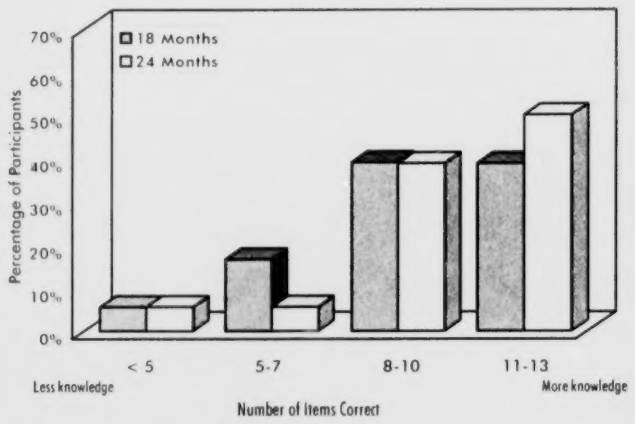
Before parents can form realistic expectations for their children they need to understand how children develop. Parent knowledge of child development is assessed using two instruments that measure general understanding of infant and toddler norms and milestones, developmental processes, and caregiving strategies. Knowledge of infant development is measured by a nine-item assessment instrument, *Raising a Baby*, with possible scores ranging from 0 to 9, where a higher score denotes better understanding of infant development and positive parenting practices. After parents have been in EHS for 18 months they are assessed by *Raising a Child*, a 13-item instrument similar to *Raising a Baby* that has been modified to include questions that are developmentally appropriate for toddlers. Possible scores on this instrument range from 0-13, with a higher score indicating better understanding of toddler development and behavior.

On both instruments, EHS parents have demonstrated improvement in their knowledge of child development over time. Parents who were assessed about their knowledge of raising a baby at program enrollment and again after 12 months of program participation showed a small but statistically significant increase, from a mean of 5.5 when they first enrolled to a mean of 6.4 after a year in the program. Parents assessed regarding their knowledge of raising a child also showed a small, statistically significant improvement, from a mean score of 9.6 after 18 months in the program to a mean of 10.3 after 24 months of program participation (Figure 6). More than one-third of parents for whom data were available at 18 and 24 months scored above the 75th percentile at both assessment periods. Of 16 parents who scored below the 75th percentile on the 18 month assessment, 13 subsequently registered improved scores on their 24 month assessment.

Responses on most items in *Raising a Child* suggest that EHS parents' knowledge of developmentally appropriate expectations for toddlers has improved. However, two items were troubling: more than half of the parents for whom data were available said they believe that "children will be bad unless they are taught what is right," and more than one-third said they

Figure 6

Knowledge of Raising a Child After 18 Months and 24 Months of Program Participation



believe that "two-year-olds often cooperate and share when they play together."

Information about adult-child relationships is also gathered through assessments of the home environment that look at interactions between children and parents. This information is obtained using two different instruments: the *Infant/Toddler Home Inventory (HOME)*, which is completed by EHS nurses; and the *Home Assessment*, which is completed by family support specialists.

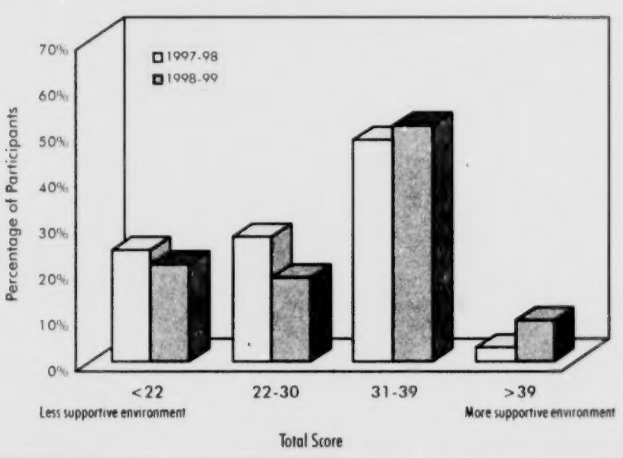
Program nurses periodically complete the 45-item *HOME* inventory for each family. Items receive one point if the specified behavior is observed during the visit or if the parent reports that the conditions or events are characteristic of the home environment. The highest possible score is 45.

Available data from the *HOME* inventory indicate that most EHS children live in supportive home environments, and that in many families their home environment showed a small but statistically significant improvement over time. For those families with a *HOME* score reported in 1997-98 and another reported score in 1998-99 (N=33), differences were analyzed between the two assessment occasions. The average score for this group on the earlier assessment was 28, with individual scores ranging from 11 to 40. On the second assessment, the average score was 31, with a range of scores from 11 to 42 (Figure 7). Six families showed considerable improvement in their *HOME* scores between the two assessment periods, and five families who had been of concern in 1997-98 improved sufficiently to move them out of that category. Meanwhile, 10 families who had been of concern remained so, and one family's assessment scores shifted from the normal range to one of concern.

Family support specialists complete the *Home Assessment*—a subset of questions adapted from the Infant/Toddler Home Inventory—as part of the parent assessment battery completed at six-month intervals throughout the program. The questions are designed to appraise the quality of stimulation and emotional supportiveness in EHS homes through a combination of semi-structured observation and interview items. The items focus

Figure 7

Home Environment: 1997-98 and 1998-99



on interactions such as parents' emotional tone with their child and their verbal responses to their child's vocalizations.

Available data from the *Home Assessment* for families after 18 months in EHS and again after 24 months in the program confirm that most children continue to live in nurturing home environments, though a slight decline in scores occurred between the two assessment periods. At both assessment times, more than half these participants registered scores in the "most nurturing" range. On a 19-question scale in which a higher score represents a more nurturing home environment, the average score at 18 months was 16.2, with individual scores ranging from 8-19. After 24 months in the program, the average score was 15.5, with a range of 6-19. One notable item is that at 24 months into the program, nearly half the parents did not provide toys for their child during the home visit.

Table 3

Mother-Child Activities

0 = not at all
1 = rarely
2 = a few times a month
3 = a few times a week
4 = about once a day
5 = more than once a day

Activity	Average Score After 18 Months in EHS	Average Score After 24 Months in EHS
Play with toys	4.5	4.4
Sing songs	4.1	3.9
Read stories	3.2	3.3
Play outside	4.0	3.9
Tease to get him/her to laugh	4.5	4.4

Additional information about parents' relationship with their children comes from the *Parent-Child Activities* questions included in the EHS parent assessment battery. The questions ask parents how often they have engaged in specific activities with their child during the previous month. Information is typically provided by the mother, but if a father is also involved with his child, questions are asked about his activities as well.

Overall, EHS mothers reported higher rates of parent-child activities at each six-month assessment occasion (six months, 12 months, 18 months, and 24 months in the program). A smaller group of parents for whom scores were available both after 18 months in the program and after 24 months reported the same general level of engagement in parent-child activities at both times. The possible range of scores for each item is 0 to 5, with 5 denoting more frequent activity and 0 denoting no activity. The overall mean score for these parents at both 18 months and 24 months of program participation was 4.0. Average scores for individual activities are illustrated in Table 3.

Fathers who are involved in their children's lives appear to be interacting with their infants and toddlers in positive ways. Scores reported by mothers for their child's father averaged 4.1 (of a possible 5.0). Seventy-five percent of the fathers fell within the higher end of the distribution range for frequent parent-child activities, while the remaining 25 percent fell in the middle. Frequencies for individual father-child activities are displayed in Table 4.

Information about parent-child relationships is also gathered through staff observations of family interactions over time. The *Parent-Child Observation Checklist* is a local instrument completed by family support specialists for each family at six month intervals. The checklist is designed to record the family support specialist's assessment of parent-child relationships across a variety of domains over an extended period of time. It *does not* measure the specific behaviors in which a parent engages with their child. Observations are made in areas that include developmentally appropriate play, verbal interaction, discipline, and health care. The checklist provides a five-point scale, with five representing highly positive relationships.

Table 4

Father-Child Activities*

Activity	Frequency					
	Several Times a Week	Once a Week	A Few Times a Month	Several Times a Year	Once or Twice in Child's Life	Not at All
Reading or telling stories	24%	24%	29%	—	5%	19%
Feeding	58%	25%	17%	—	—	—
Eating a meal together	63%	21%	13%	—	—	4%
Going to the playground or for a walk outside	55%	23%	9%	5%	—	9%
Playing at home	71%	13%	13%	4%	—	—

*As reported by the mother on the 24-month assessment
Totals may not equal 100% due to rounding
(N = 24)

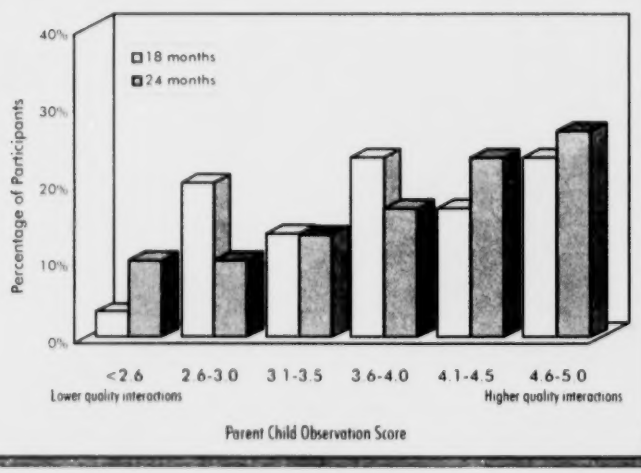
Families for whom data were available at 18 months into the program and again after 24 months displayed relationships across the spectrum from lower-quality to higher-quality at both assessment occasions, with most falling within the middle and upper end of the distribution. The average score for this group at both assessment periods was 3.8, with individual scores ranging from 1.9 to 5.0. Change scores between 18 months and 24 months indicate a small increase in the percentage of families with "higher quality" interactions. At 24 months into the program, half these families were rated by family support specialists as falling within this category (Figure 8).

Parents are questioned about their child discipline techniques as part of the parent assessment battery. The battery asks parents how they would discipline their children in three different situations. Each situation presents an example of one way in which children can misbehave, and parents are asked what they do or would do in each case. They are also asked if their child was spanked in the previous week due to misbehavior.

Parent responses indicate that they are disciplining (or would be likely to discipline) some aspects of their children's non-compliance in ways that are counter-productive to long-term healthy development. After 12 months, 18 months, and 24 months in the program, parents are generally consistent in their reports of using appropriate responses for two aspects of their children's behavior (playing with breakable things, and refusing to eat). However, the frequency of appropriate responses for two other items (child having tantrums in public, and

Figure 8

Parent-Child Interactions After 18 Months and 24 Months in Program



whether the parent had spanked their child in the previous week) has decreased significantly over time. At 12 months in the program almost three-fourths of the parents surveyed responded to these items appropriately. However, after 24 months in the program only about half these parents reported appropriate responses to children's tantrums. And almost two-thirds of the parents said they had spanked their child within the previous week. Due to this trend, the overall mean discipline score declined significantly between 12 months and 24 months.

Despite their inappropriate response to the issue of children's tantrums and their actual use of spanking, EHS participants generally feel good about their parenting ability, and this has improved over time. In periodic assessment batteries, participants are asked to choose a statement that describes how they feel about themselves as a parent. Participants responding to this question after 18 months in the program and again after 24 months of program participation indicated an increase in their belief that they were good parents. After 18 months in the program, 47 percent of these participants said they were "a better than average parent" or "a very good parent." After 24 months in EHS, 58 percent of this group characterized their parenting as better than average or very good.

Parents participating in a focus group were also unanimous in identifying "parenting" as one of the most important things with which the program has helped them. One mother commented that EHS helps parents teach kids at their [own] pace, while another said "I was a brand new mom...this gave me the support I wasn't getting at home." Parents are also supported in developing positive relationships with their children through EHS play groups. Some mothers talked about how the play group helped them learn how to interact with their children, and as one mother commented, "It helps us bond."

Considering their reliance on EHS for parenting support, many focus group parents understandably expressed trepidation at the prospect of transitioning out of the program after their child turns three. On a basic level, they were distressed at losing program support, but they were also concerned because the rules for transition seemed unclear. Family support specialists agreed that confusion existed over transition rules. They also felt that talking about transition plans didn't seem helpful to parents until the last six months prior to their departure.

Parent Mental Health

EHS program services are designed to promote parents' social and emotional development in order to support them in their role as their child's primary caregiver. Activities assist parents in using effective coping strategies in stressful situations, improving their decision-making skills, and developing positive, age-appropriate relationships. Parent social and emotional well-being was examined using established measures and EHS program data.

The lives of many EHS parents are often fraught with a variety of stressful life events. To gain some understanding of participants' life circumstances, a *General Life Events* measure (adapted from Sandler & Ramirez, 1986) was administered at enrollment and again after 12 months and 24 months of program participation. Parents were presented with 20 stressful life events and asked to indicate which of the events had occurred during the past month.

At all three assessment occasions, parents reported experiencing an average of five stressful life events during the prior month, with a wide range in the number of stressful events for individual participants. About one-quarter of each group of participants for whom data were available at specific assessment periods (enrollment, 12 months, and 24 months) reported experiencing seven or more stressful life events during the previous month, while around 15 percent reported one or no stressful life events during that time.

Financial concerns are a continuing problem for many EHS participants. At enrollment and at 12 months and 24 months into the program, half the

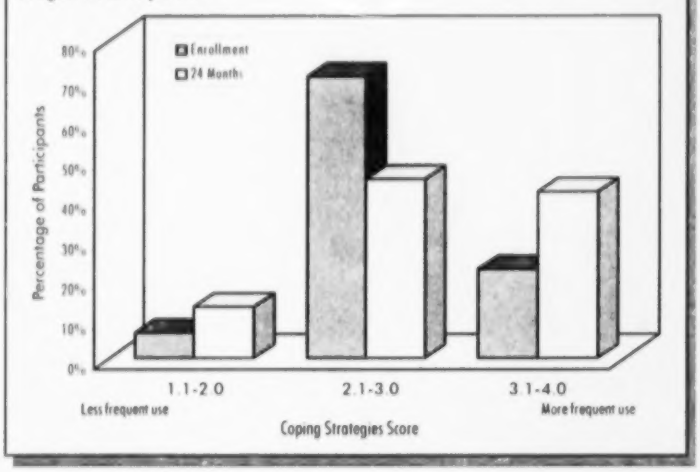
teens said their parents had talked about having serious money troubles during the previous month. Similar percentages of respondents indicated that their parents had acted very worried, upset, or sad. Thirty percent of program participants at all three assessment occasions reported that a close family member or someone they lived with had committed a crime, got in trouble with the law, or was sent to jail in the past month. And, one-third of participants at each assessment occasion said that a close family member or friend had died in the past month (see Appendix C for response rates for individual stressful life events for parents at 24 months into the program).

One way parents can help mitigate the negative effects of some of the stressful circumstances in their lives is by using positive coping strategies. To help assess this aspect of their mental health, parents periodically complete a *Coping Strategies* instrument, a compilation of 24 items from the *Children's Coping Strategies Checklist* (Preventive Intervention Research Center, 1992). The items represent young people's use of positive coping strategies, such as active problem-solving and positive thinking, to deal with stressful life situations (Ayers, Sandler, West, & Roosa, 1996). For each statement, parents indicate the degree to which they used a particular strategy to deal with their problems during the past month. Total scores range from 1 to 4, where higher scores denote more frequent use of positive coping strategies.

Based on results from *Coping Strategies*, many participants appear to be entering EHS with a moderate degree of positive coping skills, with average scores at program enrollment of 2.7 and a range from 1.3 to 3.9. This moderate level of positive coping skills was also characteristic of a group of participants assessed after 12 months in the program (N=68) and a smaller group of participants (N=37) assessed at 24 months. Although limited, trend data available for parents assessed at enrollment and again after 24 months of program participation indicate an increase in the percentage of parents with a higher degree of positive coping skills, from 22.6 percent at enrollment to 41.9 percent after 24 months (Figure 9).

Figure 9

Positive Coping Strategies at Enrollment and After 24 Months of Program Participation



In addition to the stressful events that are frequently characteristic of their lives, EHS participants are also vulnerable to stresses associated with parenting. It is important to examine these stressors because, in addition to their effect on physical and psychological functioning, they can also affect the quality of parenting. Participants periodically complete a *Parenting Stress Index (PSI)*, beginning when their children are at least three months old. This instrument is composed of 13 statements reflecting parental distress and dysfunctional parent-child interactions. Parents are asked the extent to which they agreed with each statement as true of their parenting. Possible scores range from 1 (low parenting stress) to 5 (high parenting stress).

Participants' stress related to parenting has generally continued to remain low to moderate over time. On average, participants who were assessed 12 months into the program, and again after 18 months and 24 months of participation, registered a small but statistically significant decrease in parenting stress (Table 5). Shifts in the

Table 5

Parenting Stress Index: Mean Scores at 12 Months, 18 Months, and 24 Months in Program

Time in Program	Mean Score*
12 Months	1.88
18 Months	1.79
24 Months	1.64

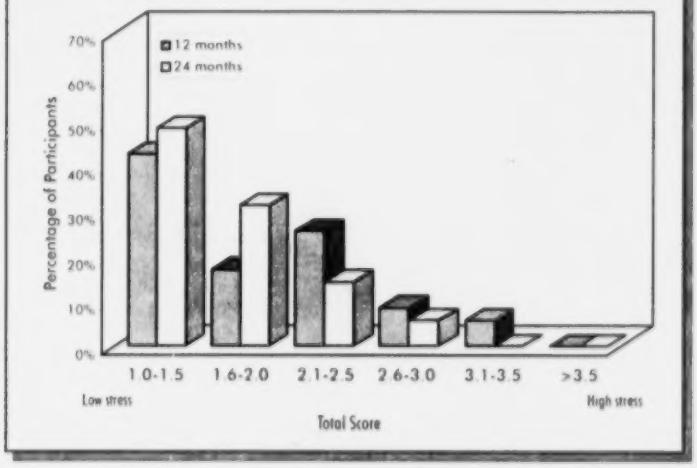
Range of Possible Scores
1.0 — Low Stress
5.0 — High Stress

*Statistically significant improvement from 12 months to 24 months and from 18 months to 24 months.

level of parenting stress reported by a group of parents assessed after 12 months in the program and again at 24 months is illustrated in Figure 10.

Figure 10

Parenting Stress After 12 Months and 24 Months of Program Participation



At all assessment occasions (6, 12, 18, and 24 months) parents continued to be most stressed about their [in]ability to handle things and their reduced ability to do things they enjoy. In addition, parents who had been in the program for 24 months indicated some stress related to misinterpretation of their child's behavior, particularly noncompliance.

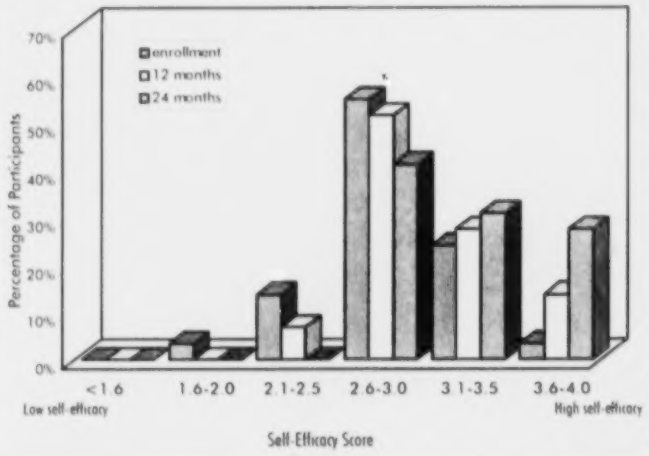
One thing that helps people deal with stress in more positive ways is their sense of control over, and responsibility for, the things that happen in their lives. EHS parents' sense of control, or self-efficacy, is assessed using a *Self-Efficacy Scale* (Master Scale, Pearlin, 1978, 1981). Parents are asked to indicate their level of agreement or disagreement with statements such as "Sometimes I feel that I'm being pushed around in life," and "What happens to me in the future mostly depends on me." Scores range from 0 to 4, with lower scores indicating low self-efficacy and higher scores reflecting high self-efficacy.

In general, parents who enrolled in EHS had a moderate sense of control over their lives, and this sense of self-efficacy has continued to increase throughout their time in the program. Available data for participants at enrollment and again after 12 months and 24 months of program participation indicate a small but statistically significant increase in self-efficacy over time. The average self-efficacy score for these parents at enrollment was 2.8, with individual scores ranging from a low of 2.0 to a high of 3.6. After 12 months in the program their average score was 3.0 (ranging from 2.4 to 3.9), while after being in the program for 24 months this group had an average self-efficacy score of 3.2 (ranging from 2.6 to 4.0) (Figure 11). Furthermore, parents showed a steady, appreciable, increase in the percentage of those registering a strong sense of self-efficacy, from 28 percent at enrollment, to 41 percent after 12 months of program participation, to 59 percent after 24 months in the program.

Self-esteem is another personal characteristic that contributes to positive mental health and helps people deal with stressful life situations. Self-esteem is measured using an adaptation of the *Self-Esteem Scale* (Rosenberg, 1965). Possible scores range from 0, denoting high self-esteem, to six, indicating low self-esteem. Parents generally entered EHS with moderately high self esteem, which continued to increase during their tenure in the program. Parents for whom data were available registered progressively higher self-esteem scores from

Figure 11

Self-Efficacy at Enrollment, 12 Months and 24 Months of Program Participation



enrollment to 12 months of program participation and again after 24 months in the program. The average score for these participants at enrollment was 1.3, improving to 1.1 (higher self-esteem) at 12 months, and 0.9 after 24 months of program participation. The distribution of their self-esteem scores over time is illustrated in Figure 12.

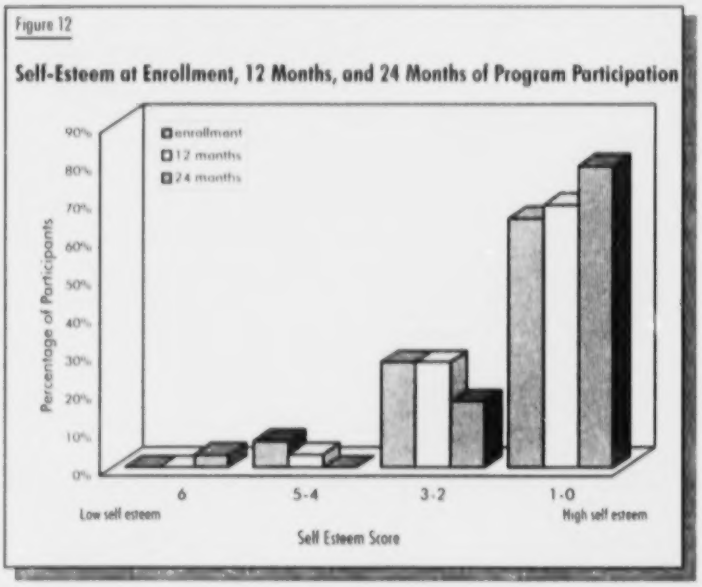
Added information related to parent mental health comes from family support specialists' assessments of participants at their semi-annual multi-disciplinary team (MDT) reviews, and from parents' personal comments. Available MDT data for participants who had been in EHS for 24 months (N=42) identified 13 parents as having been referred for mental health services. Of those, six had reportedly attended mental health appointments during the previous six months, while seven had not followed through. Family support specialists indicated that overall, 68 percent of the parents were engaging in appropriate social interaction and 88 percent were "not using illegal drugs or alcohol to the point where it interfered with jobs, parenting, school, or relationships."

Parent focus groups elicited additional thoughts about participants' social and emotional development in EHS. One mother said, "I learned to be sociable with other people. Before, I used to be very shy." A father, talking about the encouragement and opportunities he received from the EHS male involvement specialist, observed, "They bring the best out in me." Another mother said the program "gave me a lot of support when I really, really needed it most in my life.... [It gave me] a lot of self-worth. I know people are going to be there no matter what."

Family support specialists also specified self-esteem and self-sufficiency as two of the most important things EHS helps with in supporting program parents. Many related stories similar to this one about an EHS mother: "I could not get a word out of her [when she first entered the program]... now she's advocating for herself, on her own... She doesn't come to me for anything anymore." Another family support specialist described a mother who, early in the program, was involved in ongoing domestic violence and whose "self-esteem was the pits." Now the family support specialist says this mother has taken control of her life and improved

Figure 12

Self-Esteem at Enrollment, 12 Months, and 24 Months of Program Participation



her relationship with the father—and the father has become more involved with their baby.

While EHS parents and staff both identified improved parent self-esteem and self-sufficiency as key benefits of program participation, each group independently raised the issue of "setbacks" for parents with second pregnancies. A family support specialist talked about one mother who had been doing well with her first child, but "she got pregnant again… and then all her self-esteem went out the door." This feeling—that a second child affected mothers' progress and emotional well-being—was also articulated by parents during a parent focus group.

Parent Mental Health and Parent-Child Relationships

Very few statistically significant relations have emerged at 18 or 24 months of program participation between parent mental health variables of stress, self-efficacy, or coping, and parent-child relationship variables of raising a baby, home environment or parent-child activities. This is in contrast with the pattern of relations found at 12 months between parent mental health and parent-child relationship variables. At 12 months, more frequent use of positive coping correlated with higher reports of parent-child activities and a more nurturing home environment, and to more knowledge of raising a baby. Also at 12 months, higher self-efficacy correlated with a more nurturing home environment and more knowledge of raising a baby. These correlations were not found at 18 or 24 months. At 12 and 18 months, however, lower parental stress correlated to reports of a more nurturing home environment, observations of more positive interactions with children, and to more knowledge of raising a baby/child, but these correlations did not occur at 24 months into the program. One likely explanation for the failure to find significant relations between parent mental health variables and parent-child relationship variables at 24 months is that the diminished sample size at 24 months greatly reduces the power of statistical tests to detect such effects.

Statistically significant relations among indicators of parent mental health, however, appeared to continue across participants' time in the program. Parents with higher self-esteem and higher self-efficacy indicated lower levels of stress and more frequent use of positive coping skills on both their 12 month and 24 month assessments. A statistically significant correlation between more frequent use of positive coping skills and lower parental stress at 12 months was also found at 24 months of program participation. It is likely that the ability to detect these relations at 24 months despite the small sample size is due to the fact that these are more robust relations that are consistent across time.

Personal Health Care Practices

EHS program activities that support family health and wellness include ongoing monitoring of health issues during home visits, linkages to community health care providers, and site-based activities. Desired health-related outcomes for EHS parents focus on routine and preventive health care practices, appropriate perinatal care, and family planning.

Nearly three-quarters of parents for whom data were available after 24 months in EHS reportedly received services from the Arizona Health Care Cost Containment System (AHCCCS)—the state's health care program for economically disadvantaged people—at some time during the previous six months. Similar proportions of participants reportedly sought appropriate care for health problems (76 percent), and utilized preventive health care services such as well-woman exams (77 percent). Twelve parents, however, were identified at their 24 month MDT as not having a regular source for health care (*i.e.*, a "medical home").

Data about perinatal care was mixed. Of nine parents, six reportedly obtained adequate prenatal care, while three parents did not. According to reports of postnatal care, four parents received timely care, while two did not. Sixty-five percent of parents for whom data were available after 24 months in the program were reportedly utilizing some form of birth control *consistently*. The most frequently reported birth-control methods are depo-provera shots and birth control pills. And seven parents (17 percent) received family

planning services through Title X (federally funded services) during the six-month period preceding their 24 month MDT review.

EHS parents are also a source of information about program services that come under the domain of "personal health care." Participants in the Spanish-speaking parent focus group, when asked about the most important kinds of things EHS has helped with, all commented on the information they received about sex education and sexually transmitted diseases. There were several remarks similar to the parent who said "They give classes about sex...also about diseases... People find out about things they never knew before...Yes, they helped me a lot. I've learned a lot for my own self," and "They talk a lot about diseases...that you didn't even know were around...and how to prevent them."

Educational and Economic Self-Sufficiency

In helping parents move towards self-sufficiency the EHS program focus is on both education and employment, since many of the teen parents are at risk of not completing their education. Half the parents who enrolled in EHS had already dropped out of school. One program strategy for helping parents develop the foundation for long-term economic independence is to encourage and help facilitate education opportunities and/or the acquisition of job skills. Participants' progress in these areas is one of the items tracked during multi-disciplinary reviews.

Twenty-six (62 percent) of the participants for whom data were available from 24 month MDT reviews reportedly participated in some type of education or job training experience (*i.e.*, high school, community college, GED program, job training program) during the preceding six months. Of those, six people graduated or completed their program, one person advanced to the next grade level, and eight people were still attending. Eleven people (42 percent) stopped attending during the six-month period.

Follow-up information from their 30 month MDT review was available for individual parents. One of the two people reported attending GED class at the 24 month MDT had taken the GED test by the 30 month MDT; the second person had stopped attending classes. Of the three parents who were still attending high school at 24 months, one had graduated by the 30 month MDT review and another was still attending (information for the third parent was not available).

Employment-related data for EHS parents at their 24 month MDT indicate that more than half (22 people) had been employed either part-time or full-time during the prior six month period. In terms of job stability, half these parents were reportedly still working at the same job at the end of the six-month period. Three people changed jobs during this time—once, twice, and three times, respectively. The remainder had stopped working. For those people who indicated their current or last hourly salary (N=18), seven people (39 percent) earned $5.50/hour or less, and seven earned between $5.51/hour and $7.50/hour. Four people reported salaries between $7.51/hour and $9.50/hour.

Follow-up salary information was available for nine people at their 30 month MDT review. Of these, two had moved up to the next highest salary category, six remained employed within the same salary category, and one was earning less.

Access to dependable and reliable transportation and reliable child care are important factors in facilitating an individual's ability to work. Eighteen of 42 EHS participants (43 percent) for whom data were available reportedly did not have access to reliable transportation or child care. Available data indicate that more than half the parents who *were* working some time during the six-month period preceding their 24 month MDT review had regular access to a car, while one-third of the working parents used the bus. In addition, two people were in a car pool and one person walked to work. Reports about child care for those parents who were working indicated that two-thirds had a relative who cared for their child while nearly 20 percent used a child care center. Child care for the remaining working parents was provided by the child's other parent (two responses) or a friend (one response).

Employment, child care, and other indicators such as adequate housing and effective household management and budgeting skills all contribute to parents' progress towards long-term self-sufficiency. The status of EHS participants for these indicators after 24 months of program participation is presented in Table 6.

Table 6

Selected Indicators of Self-Sufficiency: Participant Status at 24 Months in Program*

Indicator	% of Participants
Employed part-time	26%
Employed full-time	26%
Living in adequate housing	88%
Access to and utilization of reliable child care	57%
Using effective household management and budgeting skills	64%

(N = 42)
*Based on staff report with parent input.

Literacy is another important factor associated with a person's ability to become economically self-sufficient. Although family support specialists and parents have identified English literacy as a problem for some EHS participants, little program activity has occurred in this area. More than one-quarter of parents entering EHS described their English-speaking and reading skills as "somewhat adequate" to "inadequate." And according to information from 24 month MDT reviews, family support specialists identified 12 of 42 parents (29 percent) who were in need of literacy classes. But program data indicate that, among all families in the past year, literacy was only discussed a total of 15 times during home visits, and none of the parents at their 24 month MDT had attended literacy classes during the previous six months. EHS program managers also mentioned having some difficulty in connecting parents with appropriate literacy services.

Parent comments in focus groups offer some added insights about program encouragement and support for education and economic self-sufficiency. These were identified by several parents as two of the most important things EHS had helped them with. While a few focus group participants felt they hadn't succeeded with many of their personal goals, others talked about accomplishments such as staying in school, graduating from high school, enrolling in college, and getting their GED. Some said that EHS helped push them toward their goals, and "sticks with them" along the way. One parent, who said she was "moving around every month" when she first enrolled in EHS, said she set a goal to be on her own and stable. She has achieved that goal: now she's finished high school, has an apartment, and is earning a living. Other parents said that EHS provided assistance with obtaining legal status, and help with securing stable and affordable housing. And one person said her family support specialist was working to get her into an apartment through Section 8 (low-income housing), while another said "[EHS staff] helped you when you didn't have a home. And then they got you a house."

For parents, there is a potential drawback to self-sufficiency—the possibility of having to transition out of the program. According to one parent asked about transitioning, "It should be when *you* think you're ready to leave, when *you* think you're self-sufficient." Parents, however, said they were unclear as to when a family had to leave. Family support specialists also reported mixed messages regarding the exact point at which a family had to leave the program.

Summary

Phoenix Early Head Start parents continued to show an improvement in their understanding of child development. Their knowledge of raising a baby registered a statistically significant increase between enrollment and one year in the program, and their knowledge of raising a toddler showed a significant increase between 18 months and 24 months in the program. Of particular note is the fact that the great majority of the parents with the lowest scores at 18 months improved their knowledge scores by 24 months.

Most indicators suggested improvements in parent-child relationships. Among the positive data, most EHS children continued to live in nurturing and supportive home situations, and some families whose home situations had been considered "of concern" in 1997-98 moved up into the normal range for 1998-99. Mothers generally reported an increase in positive interactions with their children, and also reported high rates of positive parent-child activities for the involved fathers of their children. Family support specialists recorded an increase in the quality of interactions between parents and children, and half of all EHS families were rated by family support specialists as falling into the category of "higher quality" interactions. And in surveys and discussion, parents said they felt good about their child-rearing skills and expressed the belief that EHS had helped them become better parents.

Not all parenting indicators were positive, however. Similar to last year, a large percentage of parents still exhibited some developmentally inappropriate expectations for their toddlers. Nearly half did not provide toys during a home visit at 24 months. And while many families had improved their home environment to make it more nurturing, several families remained "of concern." Furthermore, parents continued to decline in overall discipline scores, likely due to more of their children reaching the toddler stage; not only did many parents report inappropriate responses for their child's tantrums, they also reported recent use of spanking as a discipline technique.

A high number of stressful life events continued to be characteristic of EHS parents' lives in 1998-99, but without apparent effects on mental health. Surveys reported an average of five stressful events for each participant in the prior month, including relatively high numbers of financial concerns; parents who were worried, upset, or sad; and close family members or friends who were in trouble with the law, or who had died. On most measures of mental health, however, EHS parents appeared to be relatively well adjusted. According to self-reports, they maintained a moderate level of coping skills over the years with some increase in higher level coping strategies; their stress related to parenting continued to be low to moderate, with data showing a small, statistically significant decline over time; their sense of control, or self-efficacy, has continued to increase with a small but statistically significant rise over time in the program; and their self-esteem has progressively risen each year from enrollment. Furthermore, family support specialists reported that most EHS parents engaged in positive social activities and did not show signs associated with using illegal drugs or alcohol.

There may, however, be some mental health concerns for one group of parents. In interviews and focus group discussions, staff and parents both noted that some mothers who had second pregnancies experienced setbacks in their self-esteem and interruptions in their progress toward goals.

Unlike last year, few correlations emerged in 1998-99 between mental health indicators and parent-child relationships–which might be attributable to the greatly diminished sample size at 24 months. Nevertheless, some significant relations continued among the different mental health indicators: higher self-esteem and self-efficacy among parents correlated with both lower stress levels and more frequent use of coping skills, while more frequent use of coping skills correlated with lower parental stress.

Personal health care practices and efforts toward self-sufficiency showed some positive signs. Nearly three-quarters of parents at their 24 month program review had received services from AHCCCS (the state's indigent health care program) and had used preventive health care services during the previous six months. In addition, nearly two-thirds had reported using birth control consistently. These figures are higher than at the 18 month review. Also at 24 month reviews, 62 percent of parents reported receiving education or job training in the past six months, and more than half had worked full or part time, while at 30 months, several parents reported graduating or completing their program, and one had advanced to the next level. But a number of signs remained troubling. Some parents still did not get prenatal or postnatal care, and several families were without a medical home. Also, many parents who enrolled in education or training programs did not complete them, and reported wages for working parents remained low.

English literacy continued to present an obstacle that was not effectively addressed for many parents. While more than a quarter of parents entering the program felt their English literacy was less than adequate, the topic of literacy rarely came up in home visits. And while family support specialists identified more than a quarter of parents with poor literacy at their 24 month program review, none had been enrolled in classes during the last six months.

Transition issues also presented difficulties, both for parents and for family support specialists. In focus group discussions, parents and family support specialists raised a number of unresolved transition questions regarding when a family had to leave the program, and what should happen with families prior to transition.

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Child Services and Outcomes

Program services in Phoenix Early Head Start are designed to help ensure that infants and toddlers grow up in a safe, stable, and supportive environment, and benefit from enhanced opportunities for long-term intellectual, social, emotional, and physical development. A variety of program services and activities support parents in providing developmentally appropriate experiences for their young children. During home visits, family support specialists use modeling and coaching techniques to help parents learn to interact with their children using developmentally appropriate methods. The Portage child development curriculum, which was introduced during the past year, provides guidance as parents support and facilitate their children's healthy development. Monthly site-based socialization activities afford parents opportunities to learn about different aspects of early childhood development and to participate in developmentally appropriate group activities with their children. And weekly infant and toddler play groups facilitated by the child development/disabilities specialists offer experiences through which children and parents focus on play skills, language, and developmental sequencing.

Support for positive child outcomes is also provided through additional services and activities carried out by the EHS nurses and child development/disabilities specialists. The nurses assess the physical and developmental status of each child at least twice a year during home visits, and they attend the monthly site-based activities where they are available to talk with parents about child health issues and periodically facilitate specific site-based activities (e.g., nutrition). The child development/disabilities specialists facilitate parent-child play groups, consult with families and/or the family support specialists, administer child development assessments, and coordinate community resources when other intervention services are needed. They also provide support for children with special needs. Children with suspected or confirmed developmental delays are encouraged to participate in the weekly infant/toddler play groups, and special needs families receive home visits from the disabilities specialist until their referrals to outside community services are in place.

The major thrust of the EHS intervention strategy is centered on child and family development. These issues, as mentioned earlier, accounted for 57 percent of the services provided during visits with families. A variety of topics and issues fall within the child/family domain, therefore these categories can be addressed more than once during a single family visit. Child and family issues were addressed an average of three times during each home visit during the 1998-99 program year.

Parent-child play groups continue to provide additional opportunities for encouraging and supporting healthy child development and parent-child relationships. Nearly 40 percent of the mothers enrolled in EHS during the past year attended at least one play group session, with an average attendance of five sessions each. A father-child play group was also initiated during the past year in an effort to help develop and support healthy father-child relationships. At the time of this report, however, only four fathers had attended a play group session.

Phoenix Early Head Start goals and desired outcomes for children extend across four domains: infant-toddler development, developmental delays or disabilities, healthy parent-child relationships, and infant-toddler health. The status and/or progress of children in these areas are presented below.

Infant-Toddler Development

The EHS program categorizes and addresses child development services within six areas: cognitive, speech and language, social/emotional, gross motor, fine motor, and self help. Infants and toddlers who do not have developmental delays

are expected to demonstrate age-appropriate development in all areas.

The *Infant-Toddler Developmental Assessment* (IDA) is one measure used by the EHS program to assess children's developmental status. The IDA is currently designed to be administered programmatically when the child is 18 months-old and again at 30 months-old.[3] For evaluative purposes, a total "developmental score" is calculated for each child, with higher scores indicating higher functioning (maximum score=6). Analysis of IDA data for this report combines available scores from 18 month and 24 month assessment periods in order to reflect the shift in the program's testing schedule during the past year. The combination of these assessments provides information for a total of 41 children. The average IDA score for this group was 4.5, with individual scores ranging from a low of 1 to a high score of 6.

Needs and concerns were identified for 25 of the 41 children (61 percent), with an average of two categories of need/concern registered for each. While there were needs/concerns in each developmental category, speech and language continues to be identified most frequently—54 percent of children registered needs and concerns in this area. A "concern" identified in the IDA would be expected to trigger some attention on a family's individual family service plan, and thus influence the intensity of services the family receives in that domain. Analysis of program data, however, indicates that the proportion of home visits during which speech/language issues were addressed was 51 percent for families of children with concerns in speech and language, and 56 percent for families of children screened as competent.

Parents continue to articulate their belief that EHS has helped their child's development. Nearly three-fourths of parents who completed the annual parent survey said they feel their "child is better off because of EHS." Discussion among parents participating in focus groups highlighted the monthly activities and the play groups as situations where their children learned to interact with other kids. One mother commented that EHS helped her daughter be independent and also "understand that there are other people." Several parents mentioned that as part of the experience of being with other kids, their children had "learned manners." One parent said that "as a kid I had no social skills...[I] was always kept indoors...My daughter isn't having that problem." Comments from family support specialists underscore these feelings, with many support specialists indicating that one of the most positive aspects of the program for them was seeing the growth in EHS children.

Developmental Delays or Disabilities

Infants and toddlers in EHS who are identified with potential developmental delays or disabilities are expected to be referred to and receive appropriate intervention services, and to show developmental progress over time. The *Denver II*, administered by EHS nurses, is one of the instruments used by the program to identify children with developmental concerns. The current schedule (revised in 1998) for administering this screening instrument is when a baby is 45 days old, and again around 6 months, 12 months, 24 months, and 36 months. Results are reported in three categories: "within normal limits," "suspect," or "untestable." A child identified as "suspect" will be referred for further testing or retested, depending on the degree of suspicion. Children who do not cooperate with the testing process are reported as "untestable."

Denver II screenings completed for children up to 20 months of age (*i.e.*, the combination of all assessments between 0-20 months) identified fewer than 10 percent of children *not* scoring within normal limits. Within this time frame, most of the "suspect" identifications surfaced around the six-month testing occasion. Screening tests administered to infants

[3] Prior to this, the IDA was administered at 12 months, 24 months, and 36 months, with the Denver Developmental Screening administered at interim occasions. Program managers subsequently concluded that reversing the times for administering the IDA and Denver screenings would provide a better schedule developmentally and programatically.

between four and eight months old (N=114) identified seven percent as "suspect," while 93 percent of the infants were considered within normal limits. As might be expected, preliminary data suggest that the *Denver II* screening instrument identifies more children as "suspect" as they get older. Of children 19-39 months old screened during the past year (N=30), five (16.7 percent) were considered "suspect," two children were untestable, and the rest were within normal limits.

Another way that children with possible developmental delays are identified is through the family support specialists. Depending on the level of concern, some of these children are referred to the EHS child development/disabilities specialists or to other community services outside of EHS. According to information from the 24 month MDT reviews, five of nine families who had children with suspected or diagnosed disabilities, and who had been provided with referrals, had followed up on their referrals. And according to family support specialists, five of eight children with previously suspected or diagnosed disabilities had shown developmental progress over the previous six-month period.

Healthy Parent-Child Relationships

One of the major desired outcomes for the EHS intervention is that infants and toddlers in the program develop healthy relationships with their parents. The parents' attitudes, beliefs, and behaviors associated with healthy relationships between parents and children were examined in the earlier discussion of adult-child relationships. This section discusses specific parent-child interactions, child behavior, and assessment of the overall quality of these relationships.

One perspective on the overall quality of parent-child relationships is provided by family support specialists, who are asked to assess the quality of relationships for each of their families based on their observations. Data available for a group of families after 18 months in the program and for a group of families at 24 months provide family support specialists' perceptions of these parent-child interactions. While positive overall relationships were described for more of the families assessed at 24 months than for the group assessed at 18 months, family support specialists believed that slightly fewer parent-child interactions were effective at 24 months than at 18 months.

Family support specialists were asked to characterize the emotional tone of the parent-child relationship for each of their families, and to rate the overall relationship. Parent-child relationships were described as "supportive/positive" for nearly three-fourths (72 percent) of the families for whom data were available at 24 months into the program, while 19 percent of the relationships were described as "hostile/ambivalent," and 8 percent were characterized as "anxious/intrusive." This characterization is more positive than that of the group of parents who were assessed at 18 months into the program. In that group, 60 percent of parent-child relationships were described as "supportive/positive," while 17 percent were described as "hostile/ambivalent," and 23 percent were characterized as "anxious/intrusive."

The overall relationship between the parent and child was rated as "average" for half the group at both 18 months and 24 months. However, differences occurred in the other ratings. At 24 months, 31 percent of the parent-child relationships were described as "above average" and 19 percent as "below average," while at 18 months in the program, 26 percent of parent-child relationships were described as "above average" and 26 percent as "below average."

At both 18 months and 24 months into the program, family support specialists "agreed" or "strongly agreed" that nearly 77 percent of the children were "using positive strategies to seek out their parents." Family support specialists' perceptions that parents "supportively respond to their child's calls for attention" were slightly better for the families assessed at 18 months than the group appraised at 24 months (63 percent and 57 percent, respectively).

The differences in the ratings of parent-child relationships for the group of families described at 18 months into the program and the group described at 24 months are difficult to interpret.

While they might reflect actual changes in the quality of parent-child relationships, it is also possible that the differences could be due to staff turnover or individual differences in exposure to staff training. Recently hired staff might not have the same degree of training on the assessment tool as the people they replaced, thereby affecting the comparability of observation data.

Infant-Toddler Health

One important goal of EHS services and activities is to help ensure that infants and toddlers in the program are physically healthy and safe. Available program data for families who had been in EHS for 24 months suggest that, while a majority of these families are following through with appropriate health prevention and treatment activities, there is considerable room for improvement (Table 7). According to information from the 24 month MDT reviews, 20 percent of children were not up-to-date on their immunizations, nearly 40 percent were not current on well-baby/well-child checkups, and 31 percent of children were not receiving appropriate treatment for health problems. Family support specialists also indicated that six children (14 percent) did not have a medical home.

While the status of child health care practices at 24 months into the program are of some concern, available trend data are more encouraging. Limited data available for families at 24 months and again after 30 months in the program show improvement on the child health care indicators. For these families, after 30 months in the program only one child was not up-to-date on immunizations; 21 percent of the children were not current on well-baby/well-child checkups; and, 25 percent were not receiving appropriate treatment for health problems.

Table 7

Child Health Care: 24 Month Family Review

Health Care Activity	% of Children
Receiving scheduled immunizations	79.3%
Receiving scheduled well-baby/well-child checkups	60.7%
Receiving appropriate treatment for health problems	68.7%

N = 42

Information related to children's safety continues to be mixed. According to the 24 month MDT reviews, family support specialists believe that nearly half the families (45 percent) for whom data were available were *not* providing a safe home environment free from hazards. Parent self-reports, however, were more positive.

Parent knowledge and self-reported use of safety precautions is explored as part of the semi-annual parent assessment battery. These data indicate that, in general, parent knowledge and self-reported use of safety measures has improved over the course of their time in the program. Furthermore, a subset of parents for whom comparable data were available at assessment points throughout the program (12 months, 18 months, and 24 months) showed some positive changes over time (Table 8). For example, nearly all parents reportedly used car seats or other appropriate child restraints, and over time, the percentage of parents who knew whom to call if their child ingested something poisonous has increased. At their 12 month assessment, 67 percent of the parents knew the appropriate telephone numbers; this increased to 81 percent at the 24 month assessment. Despite this increase, it is noteworthy that the data suggest nearly 20 percent of these parents would not be able to respond appropriately to this kind of emergency.

One area that continues to be of particular concern is parents' knowledge and/or use of safety precautions involving electrical outlets. At all three assessment times, a large percentage of parents said they did not have covers on their unused electrical outlets—despite the fact that their children continue to be at ages and stages when they are mobile and curious.

Table 8

Safety

	12 Month Assessment	18 Month Assessment	24 Month Assessment
If you had to get the phone number of the poison control center in an emergency, do you know how to find it?			
Yes	91.2%	94.1%	94.1%
What would you do?			
Call 911	41.9%	40.6%	46.9%
Look it up	9.7%	12.5%	12.5%
Have available	25.8%	34.4%	34.4%
Search for number	3.2%	—	—
Other	19.4%	12.5%	6.3%
Do you have covers on all your electrical outlets that don't have plugs in them?			
Yes	47.1%	52.9%	44.1%
Does your home have smoke alarms?			
Yes	67.6%	76.5%	70.6%
When you take your child in the car, what kind of child restraints do you use?			
Car seat	91.2%	85.3%	81.8%
Parent's lap	5.9%	8.8%	—
No restraint	—	2.9%	3.0%
Seat Belt	2.9%	2.9%	12.1%
Booster seat	N/A	N/A	3.0%

Summary

Child development and healthy parent child relationships continued to be the central theme of home visits and play groups in 1998-99. Because of that focus, parents remained positive about EHS's impact on their child's development, reporting that the program particularly helped their child in learning to understand and interact positively with others.

Assessments of various developmental issues provided mixed results. On assessments of infant/toddler development, more than half of EHS children who were tested at 18 and 24 months had needs or concerns identified, mostly in the realm of speech and language, yet issues of speech and language were addressed somewhat less frequently with these families than with others during home visits. On assessments of developmental delays and disabilities, the overwhelming majority of children were considered within normal limits, but as would be expected, the percentage of suspected delays or disabilities increased with age. Of those previously suspected or diagnosed with disabilities, more than half had shown progress, according to family support specialists, but not all parents appeared to take action when suspected delays or disabilities were identified—slightly more than half the parents who were given referrals followed up with appointments.

Most children in EHS appeared to enjoy relatively positive relationships with their parents. Compared to last year, the number of higher quality relationships ("supportive/positive") as rated by family support specialists showed an increase from 60 percent to 72 percent, while the percentage of lower quality relationships ("hostile/ambivalent" or "anxious/intrusive") showed a substantial decline from 40 percent to 27 percent. Family support specialists also judged that—similar to last year—more than three-quarters of children used positive strategies to seek out their parents.

The areas of child health and safety continued to raise concerns, but some preliminary trend data offered encouragement. Most families at 24 months into the program practiced appropriate health prevention and treatment for their children; nevertheless, substantial numbers of children still did not receive recommended checkups and immunizations, or proper treatment for health problems. Limited data from 30 month assessments, however, showed improvement on all three indicators. Safety issues also showed encouraging trends over time, with increases in the percentage of parents who used car seats or restraints for their children, and increases in the percentage of parents who knew where to call in case of a poisoning emergency. Parents safety practices, however, did not improve regarding protection for their children from the dangers of electrical outlets.

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Staff Training and Outcomes

Fundamental grounding in child and adolescent development, and a broad knowledge of appropriate and available community resources are essential in helping EHS staff strengthen program families. Phoenix Early Head Start has developed a set of training goals to bolster staff knowledge and skills in four key areas:

- child development and parent-child relationships
- supportive alliances with families
- appropriate strategies for working with adolescent parents
- "core" knowledge necessary to implement EHS program services

During 1998-99, family support specialists attended trainings in all four key staff development areas. Outcome data for these trainings were collected by several methods, including surveys, interviews, focus group discussions, assessments of staff knowledge and skills, and review of program documents. Staff were also asked to complete a brief evaluation of each individual training session they attended.

For the purposes of this report, ratings of training sessions are analyzed only for those trainings that fell under one of the four goal areas and received two or more evaluations by family support specialists. Other EHS staff (supervisors, nurses, support personnel) also attended and evaluated many training sessions, but their ratings are not analyzed for this report because of wide differences in background, experience, and knowledge among these staff. Family support specialists also attended several trainings outside of the four key goal areas, but these, too, are not analyzed for this report.

The subsections that follow summarize staff training activities and results for each of the four desired outcome areas for the 1998-99 year. When feasible, comparisons are made of this year's results with last year's. Most comparisons, however, have been affected by turnover among key staff. During 1998-99, the EHS program manager, one site supervisor, and five family support specialists left the program.

Child Development and Parent-Child Relationships

Parents provide much of the emotional support, engagement, and continuity necessary for an infant's healthy development and acquisition of skills (Advisory Committee on Services for Families with Infants and Toddlers, 1994), and thus a central focus of EHS staff development is to build staff capacity to facilitate positive parent-child outcomes for program families. Family support specialists are expected to regularly monitor the development process of each child in the program and help shape healthy relationships between children and their parents. Some gaps in family support specialist's knowledge of child development and parent-child relationships, however, were identified by staff assessments conducted for the 1997-98 program evaluation (Sandler and Heffernon, 1999). In response, EHS committed to expanding its training efforts on these topics in a more systematic and structured manner. Beginning in January 1999, the changes took several approaches:

- ***Quarterly Child Development Trainings***. Led by the director of Child Study Laboratories at Arizona State University, the quarterly trainings included sessions on analyzing parent-child relationships and on parents' interpretation of their child's behavior.
- ***Videotape Review***. One team meeting per month at each site was devoted to reviewing and analyzing videotapes of EHS families and children. Site supervisors led the discussions.

with additional input from the child development/disabilities specialists and program nurses.

- ***"Brown Bag" sessions on child development.*** Two-hour lunchtime training sessions were instituted one Friday per month and led by EHS child development/disabilities specialists. Topics included age-appropriate activities for families, and childhood language and communication.
- ***Increased interaction with child development/ disabilities specialists.*** Family support specialists were given more opportunities to observe and assist the child development/ disabilities specialists as they worked with children during play groups and site-based activities.
- ***Developmentally-based curricula.*** Family support specialists received training on the Portage child development curriculum and also on the MacArthur speech and language assessment.

As a result of the increased focus on child development and parent-child relationships, staff development offerings in this category more than tripled, from nine trainings held in 1997-98 to a total of 29 trainings in 1998-99. This total surpassed the number of trainings offered in the other three outcome categories combined. In addition to the topics already mentioned for Brown Bag and Quarterly Child Development sessions, other trainings covered subjects such as methods of developmentally appropriate discipline, infant mental health, toy making for children, and the importance of male involvement. Fourteen of the trainings in this category were rated by two or more family support specialists, including a sampling—but not all—of the Brown Bag sessions.

As seen in Table 9, family support specialist ratings were generally high for the trainings: on a five-point scale in which 5.0 signifies staff "strongly agree" that the training was useful (*i.e.*, that it was worthwhile, they learned from it, and they will use what they learned), all but one training earned a rating of 3.5 or higher. Among the most highly rated trainings was a Quarterly

Table 9

Staff Training: Child Development/Parent-Child Relationships

Training Session	N	Training Was Useful*
Brown Bag:		
Child Development	9	4.8
Child Development	7	4.1
Language & Communication	9	4.7
Speech & Language Development	7	4.6
MacArthur Training I	8	4.6
MacArthur Training II	10	3.7
MacArthur Training Follow-up	6	3.5
Male Involvement Conference	5	4.3
Portage Training	10	4.9
Quarterly Child Development:		
Observation & Analysis	8	3.9
Observation & Analysis	11	4.6
Parent-child Interaction	7	4.6
Parent-child Interaction	8	4.9
Within Our Reach Conference	2	2.7

*Training was worthwhile, staff learned from training, will use what was learned
Ratings: Scale ranges from 5 = Strongly Agree to 1 = Strongly Disagree

Child Development session on helping parents to interpret their child's behavior (rated 4.9 overall) which, according to family support specialist comments, made good use of video examples and interaction to explain concepts. Another highly rated training provided information on using the Portage manual and guides on child development in real world situations (rated 4.9 overall); it was praised for the quality of the guide materials and the concrete examples it provided. And a highly rated training on child development that was part of the Brown Bag series (rated 4.8 overall) drew favorable comments for its hands-on approach and the demonstrations that provided useful ideas to give to parents. The one training rated below 3.0 (rated 2.7 overall) was marked down because its information was too basic and low-level for the family support specialists that attended.

How well did staff recall information presented during training on child development? To find out, the *Staff Knowledge Assessment* was administered to family support specialists in August 1999. Questions for the test were based on a SWHD child development course offered annually and attended by family support specialists. Ten of the 11 original questions on child development used in 1997-98 were also used for 1998-99.

Comparing scores on those 10 questions over two years shows an overall improvement of 5.2 percent in 1998-99 over the previous year (Table 10). It is important to note that the overall scores include all family support specialists, whether or not they had attended the child development course prior to the assessment. These scores, therefore, describe differences in overall staff knowledge of child development at these two assessment periods, and account for staff's previous knowledge as well as information tied specifically to this particular training. Family support specialists generally scored highest on questions asking them to list cues from overstimulated babies, developmental milestones for infants and toddlers, elements of language acquisition in babies, and ways to use observation with families.

Table 10

Staff Knowledge Assessment Scores*: 1997-98 and 1998-99

	97-98	98-99	% change
All Staff (N = 10)	7.7	8.1	5.2%
Staff employed > 1 year and attended class (N = 5)	7.4	8.7	17.6%

*Maximum score = 10

On each of the two Staff Knowledge Assessments (1997-98 and 1998-99), only five of the family support specialists who responded had been employed by EHS for at least 12 months and had completed the child development course. And due to staff turnover, not all five family support specialists were the same for both years. The comparison of results for these two groups shows a 17 percent improvement from 1997-98 to 1998-99.

Most importantly, did staff training make a difference in the way family support specialists work with families? To address this critical question, family support specialists were again assessed using the Phoenix Early Head Start *Staff Video-clip Analysis*, which was originally developed in 1997-98 by EHS/SWHD managers and child development specialists in collaboration with program evaluators. This assessment evaluates staff knowledge and skills in understanding child development and parent-child interactions.

For the assessment, family support specialists were shown two videotaped examples of actual parent-child interactions: first, a mother with an 11-month-old child, and second, a mother with a 24-month-old child. After each video-clip, the family support specialists were asked to address two key areas—parent-child interactions and child development—and for each area identify critical strengths, critical concerns, and areas needing further assessment. Then they were asked to create a list of objectives, activities, and indicators of progress that they would use to work with each family in each area.

Family support specialists received two scores for each video-clip. The "exemplar" score totals the number of correct *examples* of a concept or key issue that the family support specialist was able to identify. The "conceptual" score totals the number of times the family support specialist named the *actual concept* involved—a higher level analysis. "Total hits" are obtained by combining the number of exemplar and conceptual identifications. Results are reported only for those family support specialists who had been employed with EHS for more than three months prior to the assessment (Table 11).

On the first video-clip (11-month-old), which contained 29 possible hits, individual family support specialist's total hits ranged from 8 to 15 with an average of 11.9; of those hits, conceptual scores ranged from 1 to 7, with an average of 3.6. On the second video clip (24-month-old), which contained 24 possible hits, total hits ranged from

Table 11

Staff Videoclip Analysis—Child Development and Parent-Child Interactions: 1997-98 and 1998-99

	% Total Hits*		% Conceptual Hits**	
	1997-98	1998-99	1997-98	1998-99
Clip 1: Infant[1]				
staff employed > 3 months-12 months	42.6%	39.1%	7.4%	10.3%
staff employed > 12 months	60.0%	42.1%	11.1%	13.8%
Clip 2: Toddler[2]				
staff employed > 3 months-12 months	63.3%	61.1%	14.2%	15.3%
staff employed > 12 months	58.7%	58.3%	16.0%	24.2%

*percentage of issues identified by either example or concept
**percentage of issues identified by concept only
[1]97-98 clip: 9-month-old; 98-99 clip: 11-month-old
[2]97-98 clip: 18-month-old; 98-99 clip: 24-month-old
staff employed > 3 months - 12 months: 97-98 (N = 4); 98-99 (N = 3)
staff employed > 12 months: 97-98 (N = 5); 98-99 (N = 5)

6 to 20 with an average of 14.3; of those hits, conceptual scores ranged from 0 to 10 with an average of 5.0.

Comparing scores from this year's video-clip analysis to last year's provides mixed results on the effects of staff training over the course of the last 12 months. Five family support specialists each year had been employed by EHS for more than 12 months at the time of the video-clip analysis, and they presumably had the most exposure to training. Table 11 shows that family support specialists who had been with EHS for more than 12 months at the time of the 1997-98 video-clip analysis were able to identify more issues of child development and parent-child relations than a similar group of family support specialists in 1998-99. However, in 1998-99, these family support specialists were able to identify more of the higher level concepts than the group did in 1997-98. (Percentages of "hits" are used for comparison rather than actual numbers, because the video-clips each year used different parent-child dyads, resulting in different numbers of possible issues.)

Overall, results from the video-clip analysis point to some improvements in staff knowledge of issues in child development and parent-child relationships—particularly in terms of the concepts that underlie those issues. Family support specialists have shown they can identify many of these issues and concepts in real interactions, and they can determine when they are strengths for families and when they are concerns. Nevertheless, family support specialists still have difficulty using their insights to generate intervention goals and activities. Also, a number of concepts continue to elude their identification.

In surveys, interviews, and focus group discussions, various EHS staff also talked about staff training related to child development/parent-child relationships. Overwhelmingly, family support specialists, supervisors, and administrators described the monthly Brown Bag sessions, monthly videotape review, and increased child development trainings as extremely helpful, as were the increased availability and contact with program child development/disabilities specialists. Family support specialists were very pleased that the training agenda had been responsive to their requests and needs, both in focus and in style (*i.e.*, more "hands-on" and practical).

One obstacle to the success of training, according to family support specialist comments, was lack of planning time. Family support specialists said they now have the tools to work on child development and parent-child issues during home visits, but they don't have enough time to plan their visits for maximum effect.

Another major obstacle mentioned was the large turnover among staff that created difficulties getting new employees up to speed, particularly with respect to child development training. Staff's self-assessment of their knowledge supports these comments. On survey questions related to child development and parent-child relationships, family support specialists who had been employed less than three months rated themselves more than one point lower than more experienced staff.

Not explained by staff turnover, however, is that family support specialists this year rated their knowledge on the child development and parent-child relationship items lower than did family support specialists the previous year. This held true overall, and also when comparing groups of family support specialists with similar length of employment across the two years.

Supportive Alliances With Families

Establishing a positive relationship between provider and parent is considered one of the key factors in achieving a successful intervention for infants or young children. Provider-parent relationships that strengthen a parent's feelings of acceptance and appreciation can, in turn, lead to parent-child relationships that are more positive (Kalmanson & Seligman, 1992).

Two trainings during 1998-99 focused on developing supportive relationships with families. These sessions addressed methods for working with difficult families, and issues related to home visiting. Neither training was rated by family support specialists.

Despite the small number of trainings in this area, supervisor surveys show that family support specialists are perceived as working well with families. Staff surveys support this perception: on items that assessed supportive alliances with families, family support specialists either "strongly agreed" or "agreed" with most key program concepts (*e.g.*, collaborative planning, genuine and authentic interactions). In contrast to the previous year, issues that involve setting appropriate boundaries with families did not arise as problematic in survey and interview data.

Parent survey data continue to indicate that family support specialists have generally succeeded at developing supportive alliances with families. Many of the items on the parent survey are designed to elicit information about different elements of supportive relationships. And the majority of parents "strongly agreed" or agreed with all the items characteristic of supportive alliances.

Strategies For Adolescent Parents

One of the unique challenges facing family support specialists in the Phoenix Early Head Start program is that parents in the target population are adolescents. Family support specialists, therefore, must understand adolescent development and possess effective strategies for working with them in order to encourage better child and family outcomes for EHS families.

Two training sessions during 1998-99 related to strategies for working with adolescent parents. These sessions addressed problem solving and communicating with adolescents, and pregnancy prevention among teenagers. Neither training was rated by family support specialists.

Supervisors' ratings of individual staff indicate that family support specialists are using appropriate strategies for working with teen parents. On staff surveys of knowledge, however, family support specialists rated themselves between "moderate" and "barely adequate" on items related to working with teens (*e.g.*, recognizing risk and protective factors; the importance of mentoring), a slight drop from their ratings last year. Some family support specialists asked for more trainings that discuss working with adolescents. Some also mentioned a downside to this year's intense focus on child development and parent-child relationships; they were no longer sure when it would be appropriate to attend to crisis management with parents.

Core Knowledge

Family support specialists need basic knowledge of a number of widely varied subjects in order to successfully implement EHS program services. Among these subject are adolescent health and development, family planning, perinatal and well-child care, and community-based services and resources. With the exception of adolescent health and development, which has already been discussed in the category "Strategies for Adolescent Parents," these subjects are grouped under the category "Core Knowledge."

During 1998-99, a total of 18 training sessions dealt with subjects considered to be core knowledge for EHS staff. Among these were sessions on child nutrition, lead poisoning, tooth decay in infants, working with food banks, protecting children from violence, recognizing gang behavior, and practicing CPR and first aid.

Five of these training sessions were rated by more than one family support specialist (Table 12). Ratings on the usefulness of these trainings were high overall, ranging from a low of 4.3 to a high of 5.0. The highest rated training, which addressed oral health in babies, received comments that it thoroughly explained such topics as baby bottle tooth decay and the development of cavities, yet it did so in an interesting manner that employed humor and simple language. Another training on nutrition and anemia (4.3 overall) was praised for being informative and to the point—and for providing useful handouts on the subject in both English and Spanish.

Table 12

Staff Training: Core Knowledge

Training Session	N	Training Was Useful*
CPR/First Aid	4	4.8
Lead Poisoning	8	4.7
Nutrition/Anemia	9	4.3
Oral Health Baby Bottle Tooth Decay	9	5.0
Reading and Writing Creatively	3	4.6

*Training was worthwhile; staff learned from training; will use what was learned
Ratings: Scale ranges from 5 = Strongly Agree to 1 = Strongly Disagree

As might be expected, staff survey data indicate a dichotomy between veteran and relatively new family support specialists in terms of their core knowledge. Family support specialists with more than three months experience generally said they feel comfortable with their overall knowledge of core subjects, and either "strongly agree" or "agree" they have sufficient knowledge and are well prepared to carry out the goals of the program, while family support specialists with less than three months experience said they feel unprepared and unsure. Evaluating several specific core knowledge items on the survey, family support specialists generally rated themselves moderate, a slightly lower rating overall than given the previous year, particularly for items related to child abuse, community violence, and childhood diseases. Some family support specialists also requested more training and information on male involvement.

One continuing issue cuts across all training categories: staff turnover and its related effects. The departure of the program manager and one site supervisor in the past year, and the temporary vacancies these created, led to what some characterized as a "leadership vacuum" that carried down to staff at all levels. One problem according to staff, was a lack of new employee orientation—not only for new family support specialists, but also for the new site supervisor. In focus groups and interviews, staff again this year said that inadequate training for new family support specialists left them unclear about program priorities, policies, and the roles of support personnel. Related to this issue are perceived inconsistencies in supervision. Family support specialists indicated they found differences in the degree to which they received helpful guidance from their supervisors, due at least in part to the turnover in that position. The supervisors, in turn, noted they faced a continuing challenge in trying to retain experienced and capable staff; supervisors had no career ladder or salary path at their disposal to reward the contributions of long-term personnel.

Summary

In response to identified gaps in family support specialist knowledge of child development and parent-child relationships, Phoenix Early Head Start embarked on a greatly expanded training agenda for 1999. The new agenda featured a systematic schedule of child development offerings that, as requested by family support specialists, took a more practical, "hands-on"

approach than in the past, and was targeted at specific EHS needs. The training agenda also extended other opportunities for family support specialists, such as scheduling them to work closely with child development/disabilities specialists during activities with children.

While the new training agenda was well received by family support specialists, results of the effort are mixed so far. On the positive side, most of the trainings were considered to be very helpful by family support specialists, staff were considered by their supervisors to be stronger in this area, and an assessment of staff knowledge in child development showed gains over the previous year, particularly for those family support specialists who had received the most training. However, family support specialists rated themselves somewhat lower than last year on their knowledge of child development, and they were unable to identify as many issues of child development and parent-child relationships when watching children on video-clips. They did, however, demonstrate higher-level understanding of the issues they could identify.

Many of the results of staff training data reflect the continuing influence of staff turnover on overall family support specialist performance and perception of their skills. Staff with longer EHS employment—and who consequently benefitted from more training opportunities—generally scored higher than their less experienced and less trained counterparts on most objective and subjective measures. In one of the most prominent differences, longer-term employees when surveyed said they felt well prepared to do their jobs, while the newest employees felt unprepared.

Interrelated with the staff turnover problem is the issue of new employee orientation, which had improved briefly then faltered during the year apparently due to changes in management/ supervisory personnel. Similar to last year, staff requested a more focused and systematic approach to bringing new employees up to speed on basic program operations and values. Some also asked for more consistency and substance in their supervision.

With the intensified focus on child development and parent-child issues this year, other training goal areas received less attention. While the indicators show that most family support specialists are working well with their families and have sufficient core knowledge to do their jobs, some staff would not like to see these topics ignored, particularly issues related to understanding adolescents and the role of male involvement. In a positive change from last year, however, issues of setting appropriate boundaries with families did not appear to pose any significant problems for family support specialists.

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Community Outcomes

While foremost a child and family development program, the national Early Head Start initiative identified the importance of not only providing services, but also creating a community environment that supports very young children and their families. Community-building, therefore, is one of four program cornerstones considered essential for high-quality comprehensive programs. Revised Head Start Program Performance standards (*Federal Register*, November 5, 1996) indicate that grantees "must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs, and to ensure that Early Head Start and Head Start programs respond to community needs..." The revised standards also direct grantees to "take an active role in community planning to encourage strong communication, cooperation, and sharing of information among agencies and their community partners to improve the delivery of community services to children and families." (Subpart C, 1304.41, (a)1, (a)2).

Phoenix Early Head Start program goals reflect national performance standards through the following desired community outcomes: 1) to facilitate the development of parent/child support services (e.g., child care, health, and education), and 2) to establish relationships with community service providers and provide coordinated services to program families. A third desired outcome, on a broader policy level, proposes to translate knowledge gained from the program into state and local actions to address the needs of very young children and their families.

Information about community outcomes is gathered from several sources: review of program documents, observations of selected staff meetings, and annual interviews and focus groups. Periodic meetings between the program evaluator and program administrators also facilitate ongoing reflection about larger scale collaborative initiatives. Specific documentation of EHS community activities can be found in the program's quarterly administrative reports. This report takes a broader look at community outcomes. It appraises EHS progress in establishing accessible service networks and developing collaborative leadership efforts to improve the community environment for vulnerable young families.

Achievement of the program's desired community outcomes is primarily pursued on three fronts: linkages, collaboration, and leadership. EHS participants are linked with existing community services to help them with specific needs; collaborative relationships are developed with other programs and agencies to maximize community resources and help fill service gaps; and, on a broader level, program administrators pursue actions to develop more integrated, comprehensive, service networks and marshal public support for children birth-to-three and their families.

As with any ongoing program, EHS has experienced an "ebb and flow" relationship with the community groups with which they have interacted over time. Some relationships have remained the same, continuing to link EHS participants with ongoing community services. Others have experienced changes, moving from linkage to collaboration and back to linkage. Still other community relationships have steadily progressed, moving from community resource to linkage to bona fide collaboration.

Establishing Linkages

Linkages with several agencies over the years continue to benefit EHS participants. A grant early in the program from the Red Cross has enabled EHS nurses to provide periodic training and certification for program parents in CPR/First

Aid and child care. Consequently, some teens who have completed a child care course have been able to earn money providing child care during EHS activities. A continuing linkage with Planned Parenthood also benefits program participants in several ways, from easier access to affordable family planning services to periodic program activities focused on sexuality and sexually transmitted diseases. EHS and Planned Parenthood, along with the Arizona Family Planning Council and other agencies, have also worked together on joint endeavors such as grant applications for family planning services.

Linkages with other community resources have changed over time. A linkage with the Youth Care organization originally connected EHS parents with HIV/STD prevention classes designed for sexually active 16-19 year olds, and offered the EHS program financial incentives based on class registration. While the classes were of benefit to EHS participants, the services became unavailable during the past year when Youth Care lost its funding. Another linkage with "Breaking the Cycle," a community-based health services program for people without a regular source of health care, did not become as successful as program managers anticipated. The program's service hours and location did not work well for many EHS parents, consequently the linkage faltered.

Some linkages, however, have strengthened. One example is the ongoing relationship with the Department of Economic Security's Division of Child Support Enforcement (DCSE). Not only has the agency continued to address the needs of EHS parents, but EHS has also continued to assist agency staff in understanding the most supportive ways to help young families.

The EHS relationship with the Village charter school for pregnant and parenting teens illustrates yet another path in the course of linking and partnering. What started as a linkage between EHS and the Village to provide educational placements for parents the first program year, expanded to a bona fide collaboration the following year, when SWHD took over temporary management of the school's child care facility by providing professional and financial resources. During the past year, however, the collaboration waned as the Village resumed management of its child care facility and reportedly grappled with internal issues. The consensus among EHS managers and administrators at the end of the 1998-99 program year was that the Village was functioning simply as a resource and referral source for EHS parents. At the time of this report, however, EHS/SWHD administrators indicated that this relationship was again being revisited, and would likely be broadened in the coming year.

EHS/SWHD administrators have also been working during the past year to develop a linkage that will place EHS families in a child enrichment center being developed by Crisis Nursery. If established, this link would increase child care options for parents as the center can accommodate infants as well as toddlers and preschoolers. In addition, plans are underway for SWHD, in partnership with the Osborn School District, to operate a child care program for one to two-year-olds starting next year. The program will be housed in a modular building on the campus of one of the district's elementary schools.

EHS has also initiated activities related to employment and job training, an important element in helping parents move towards self-sufficiency. Several EHS parents are involved in the City of Phoenix Youth Build program, which offers training and education opportunities in the construction industry. EHS is also one of the programs included in a proposal by the City of Phoenix Human Services Department for a Youth Opportunity Grant submitted to the U.S. Department of Labor. As part of this proposal EHS would be able to refer participants to job training or education programs funded through the grant.

Expanding Resources

When programs and organizations join forces and coordinate their resources, they enhance existing services, maximize benefits for families, and generate new solutions for problems. Two notable illustrations of this process are the EHS partnerships with the City of Phoenix Step-Up Program for young fathers and the Young Fathers Network, a community partnership among local

programs serving young fathers. With SWHD as a collaborator, the Young Fathers Network received a grant to provide services to young fathers whose children receive financial support through TANF. Phoenix Early Head Start plays a role in this effort by serving on the technical assistance committee that guides the program's development, and through the active involvement of the EHS male involvement specialist.

The EHS relationship with Step-Up has grown more collaborative during the past year as well. The collaboration has included joint planning and pooling of resources for a successful Father's Day picnic, participation and recognition of EHS families at the annual Step-Up awards banquet, and attendance by the EHS male involvement specialist at Step-Up program meetings. One consequence of the EHS program's emphasis on male involvement is that SWHD has taken a prominent community role in young father issues —from coordination and sponsorship of male involvement conferences to management of a grant program to provide local "father programs" with training and technical assistance. In several of these efforts, SWHD has partnered with public entities such as the City of Phoenix Human Resources Department and the Arizona Department of Economic Security.

During the past few years, EHS has also joined forces with the state Developmental Disabilities Division (DDD) and Early Intervention Program (AZEIP) to help coordinate services for special needs families. A team composed of staff from both agencies plus an EHS parent have continued to benefit from participation in a national Early Head Start training initiative to support families with children with disabilities. Joint quarterly meetings between the agencies have also continued over the past year, promoting a more integrated approach to addressing families' needs.

Developing Integrated and Comprehensive Services

Phoenix Early Head Start is currently following several paths toward developing more integrated, comprehensive services for the support of children birth-to-three and their parents.

Expanding resources is one important step in that direction. As discussed earlier, alliances with DDD and AZEIP have begun to weave together available services for families with special needs children, while the Young Fathers Network has helped expand the scope of services for young men. Adding to these efforts are the benefits that derive from EHS's relationship with other SWHD initiatives, such as the agency's participation in AZEIP, the Good Fit Center's leadership of a statewide infant mental health consortium, and the agency's recent grant, mentioned earlier, to provide technical assistance to groups working with young fathers throughout the community.

Through their participation in a variety of broader activities, EHS and SWHD administrators have also continued to use their experience and knowledge to expand and integrate services that support very young children and their families. EHS managers and staff remain committed to integrating birth-to-three issues into the early childhood policy arena through their continued participation in the Arizona State Head Start Association, and SWHD has helped lobby for increased child care subsidies through its involvement in initiatives such as the statewide child care advisory committee.

Knowledge gained from EHS and other agency programs has contributed to Southwest Human Development's key role in a statewide initiative called "Smart Beginnings," a research, planning, and system development effort to design a public/private model for supporting families and promoting the healthy development of children prenatally through age three. Leadership for this project has been provided through a partnership between Southwest Human Development and the Children's Action Alliance, a child advocacy organization, with funding from St. Luke's Charitable Trust. Smart Beginnings is focused on three goals: to design a zero-to-three family support system for providing a continuum of services, to advocate for improvements in infant and toddler child care, and to create a public awareness and parent education strategy that will inform families about child development and encourage them to promote healthy development of their children.

Technical Assistance

Growing public recognition that the 0-3 years are critical, along with the increased availability of funds, has allowed new Early Head Start programs to be implemented across the country. In this process, Phoenix Early Head Start has continued to provide technical assistance to agencies interested in developing new Early Head Start programs, thereby helping communities – both locally and nationally – increase their capacity to serve very young children and their families. As part of this effort, according to program administrators, EHS managers and staff provide consultation and guidance to new programs, including on-site visits to help people see for themselves how Phoenix Early Head Start works. With information about the program design and the benefit of "lessons learned" through EHS experiences, these groups are better prepared to assist children and families in their own communities.

Summary

As with any long-term, multi-faceted program, some EHS community connections and relationships have changed over time, and some efforts have been more successful than others. These fluctuations in program relationships are to be expected. But while EHS has developed many community linkages and partnerships over the course of the past four years, most program stakeholders felt that only limited progress had been made during the 1998-99 program year in terms of the *evolvement* of linkages and collaborations. Plans, however, appear to be underway for new linkages and activities. At the time of this report, program administrators anticipated that a number of emerging relationships would be established in the coming year to better address the education and child care needs of EHS families. These include a revitalized relationship with the Phoenix Union High School District, restored and renewed activities with the Village charter school, and alliances with both the Crisis Nursery and the Osborn School District.

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Summary and Analysis

At the end of the 1998-99 project year—Year Four of the five-year EHS demonstration grant and the third full year of program implementation—Phoenix Early Head Start continues to be on the right track. An array of services are in place to assist program families, an expanded staff training agenda on child development is helping family support specialists in their work with parents and children, and a range of community linkages and partnerships are helping expand resources and options for families. The subsections that follow discuss progress and outcomes for EHS children, families, and staff during the 1998-99 program year.

Children and Families

EHS services are designed to assist low-income children and their teen parents in several ways: they support children's health and development, they help the teen parents—both mothers and fathers—become better caregivers, and they assist families in becoming more economically self-sufficient. Key to the program's strategies are regular and frequent home visits by family support specialists and other resource staff. During these visits, issues of child development and parent-child relationships predominate. Additional support for parents and children comes from parent-child play groups, site-based socialization activities, parent support group meetings, and outside referrals.

Program services appear to be having a positive impact in several areas, particularly regarding parent knowledge of child development, parent-child relationships, and family development. Results show that as parents have progressed in the program, many have gained knowledge about raising infants and toddlers, they have engaged in more positive interactions with their children, and they have provided more nurturing home environments. Many parents have also maintained relatively positive mental health in the face of continuing life stressors, and many have worked toward self-sufficiency by holding jobs or attending school or training programs. In addition, they have shown overall improvement in the area of health care: more parents are using birth control consistently, more are practicing appropriate health prevention and treatment for themselves and their children, and more are using appropriate safety practices at home and in cars.

Some areas of concern persist, however. Speech and language development remains an issue for a large portion of EHS children. Many parents still hold unrealistic expectations for toddlers and resort more often to spanking and other inappropriate forms of discipline. Medical care for families is still not universal, and in some cases mothers are not getting prenatal or postnatal care. Some mothers who have experienced second pregnancies report lower self-esteem and difficulty in meeting goals. Literacy levels for many parents remain low, making it difficult for them to pursue their education or qualify for good-paying jobs, yet few are attending programs to improve their literacy. And transition policies have not been fully clarified for families leaving the program, leading to areas of confusion among parents and staff.

Elements of the male involvement program component also merit some further consideration. While the male involvement effort has engaged many fathers in the lives of their children, and has proven to be a tremendous asset in placing EHS/SWHD in a leadership role in this area, it remains something of an enigma to family support specialists. They continue to have questions about integrating the male involvement component into family service delivery plans, particularly regarding key program goals such as child development and parent-child relationships. Despite several training sessions on male involvement through the years, there is still a lack of clarity regarding how family

support specialists can routinely coordinate with male program services.

Overall, however, the services provided by EHS appear to be hitting their targets. Parents feel good about their parenting skills and are growing in their roles as caregivers. Their children are living in more nurturing environments. They have come to trust and rely on staff and support groups to provide positive assistance without any hidden agendas. Even the nature of some expressed concerns can actually be viewed as evidence of program success. Transition, for example, wouldn't pose a threat to parents if they didn't feel they were losing something valuable in the EHS support system.

The fact that some issues persist year after year is troubling, but that might simply hint at the size and scope of the problems involved in trying to assist young families with multiple risk factors. As services are concentrated in one area—such as child development—other areas—such as literacy—may sometimes slip through the cracks. Already, family support specialists note the need for more planning time in order to incorporate all of their "must-do" services into a weekly home visit. Given the breadth of the EHS intervention, perhaps staff will always face a conundrum in balancing the scale of program services for families.

Staff Development

Phoenix Early Head Start's primary program goals are to provide comprehensive services that enhance parent-child relationships and promote positive child development. The intent of staff training is to increase knowledge and skills in these domains so that family support specialists can work effectively toward desired program outcomes. To provide family support specialists with more focused, hands-on training, an expanded and more systematic training agenda was implemented in 1999, and a child development curriculum was adopted. EHS staff generally found the new training agenda useful and responsive to their needs; however, outcomes from the trainings thus far are mixed.

While staff knowledge of child development and parent-child relationships has improved since last year, and family support specialists have demonstrated better understanding of some higher-level concepts, a number of concepts have continued to elude them. To help family support specialists not only understand the nature and importance of these concepts but also apply them in their work with families, regular use of "conceptual language" must become part of the daily program dialogue. For this to occur, program administrators, managers, and supervisors must agree on the concepts, their definitions, and their usefulness, so that everyone uses them consistently.

The intensified emphasis on child development and parent-child relationships was generally embraced and appreciated by family support specialists, but it resulted in reduced training focus on issues related to teen parents. Though most indicators suggest that staff are continuing to work well with their families, some family support specialists expressed the need for more training on understanding adolescents. Considering that this age is one of the most complex to work with, and in view of the small number of trainings family support specialists have had regarding strategies to use with adolescents, it would seem prudent to pursue more training in this area.

Staff training results reflect the continuing impact of high staff turnover. Comprehensive and systematic training is most effective when staff members are retained long enough to build on their previous trainings. Nevertheless, all programs experience some degree of staff turnover, so it is also important to have mechanisms in place to bring new employees up to speed as quickly and seamlessly as possible. Program administrators, therefore, should focus attention and resources on two areas: improved retention of current staff, and efficient orientation of new staff on basic program operations, strategies, and values. As of this report, program managers had begun taking steps toward these goals.

Staff training activities must always keep in mind that Phoenix Early Head Start is first and foremost a child development program. This year's staff training emphasis on child development and

parent-child relationships marked a critical step forward in ensuring progress toward the program's top-priority program goals. It will be important in the coming year not only to continue these training opportunities, but also to maintain a balanced training effort that includes examination of adolescent-related issues.

Remaining Challenges

As EHS moves into the final year of its current five-year program cycle, some challenges remain. Among them is concern over the literacy and education levels of program participants. Program managers and administrators generally share the conviction that a number of EHS parents should be connected with programs to improve their literacy during the upcoming year. Previous efforts to do so, however, have not proven successful. They also note two major difficulties facing any effort to get parents to continue or resume their education: 1) there is a need for more educational avenues because relatively few programs exist for teen parents, and 2) it is often hard to motivate disenfranchised young people to access programs that *do* exist. In regard to the latter issue, one person asked: "How much do you get involved in kids' lives?" That question reflects the quandary of many staff over where to set limits when it comes to helping teens make appropriate choices.

Another challenge—one that has been previously discussed—is the recruitment and retention of family support specialists. Both staff and managers share concerns over the lack of advancement opportunities within the EHS program. They have also pointed out that this situation contributes to the loss of the most "established" and well-trained personnel—the people who have built the most secure and supportive alliances with families. At the time of this report, program administrators were taking steps to address this issue.

A third program challenge involves the "management" of the transition process when families become ineligible for program services—particularly the need for a coordinated and clear message regarding the elements of transition. This issue surfaced during conversations with EHS parents. Participants in one parent focus group voiced a great deal of concern over the transition process, saying they had received inconsistent information about when, and under what circumstances, they would have to leave the program. They also proposed that they—a group of experienced parent "leaders"—should be allowed to continue with EHS because their participation was a benefit to the program. Parents in a second focus group, however, appeared to be more accepting of the transition requirement, but they, too, said they had received mixed messages. The lack of clarity regarding transition was underscored by the focus group discussion with family support specialists, in which it was evident that they also had differing perceptions about the "rules and requirements" of transition.

A final program challenge identified by EHS/SWHD administrators concerns how best to disseminate "knowledge gained" from the program into the larger community. While much has been learned through the EHS experience about the needs of teen parent families, the challenge facing the program is to effectively communicate that knowledge to educators and policy makers. The same issue also surfaced at the end of 1997-98, but the shared perception is that little progress has been made since then.

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A State and Local Policy Perspective: Building Community Capacity to Support Children Birth to Three and Their Teen Parents

What does it mean to "build community capacity" to support young children and their families? For a program that serves children and parents, the goal of building community capacity seems both appropriate and desirable. Yet it also presents a concept that eludes precise definition. This section will examine the paths taken and progress made by Phoenix Early Head Start thus far in developing a community environment that supports the needs of young children and their teen parents. The discussion will also address the challenges that face programs such as this as they unfold, mature, and ultimately contribute to the development of community capacity to meet the needs of teen famiiies.

Building a Foundation

Phoenix Early Head start has learned a great deal in the past three years about how to improve the lives of young children and their teen parents. Some lessons have come in the course of providing program services; other have come from the continuous program improvement evaluation. Together, these experiences have furnished EHS/SWHD administrators with an arsenal of information with which to help individual families and, equally important, to identify and facilitate appropriate community level strategies that can help a larger population of families. Thus, at the end of the third year of program implementation, EHS has stayed on track in its efforts to provide intensive services to program families. The program has also begun to lay groundwork for longer-term community change—what is referred to as the program's "community legacy." This is its contribution towards developing a community environment responsive to the needs of young children and their teen parents.

"Community legacy is sometimes hard to see immediately," said one EHS administrator when asked to discuss the program's long-term effects. While this is true, some signs of progress are visible in three areas: male involvement, issues related to teen parents, and staff training regarding child development and home visiting. EHS has clearly helped broaden the reach of male involvement programs throughout the community, and it is raising the level of fathers' involvement in their children's lives. The program has also gained considerable knowledge about the needs of teen parents and the types of policies and services that communities should have in place to help them succeed. And over the past four years, the program has learned a great deal about how to train staff who work with children 0-3 and their families. This knowledge is now being incorporated into agency-level staff training at Southwest Human Development, and thus will be extended to other agency programs in the community.

In fact, much of what has been learned through EHS is being integrated into the overall Southwest Human Development agency philosophy, according to administrators. And, because of the agency's leadership position in the early intervention and infant mental health arena, this knowledge will be disseminated into the larger early care and early intervention communities as well—benefitting many of the young children and families with whom they work.

Challenges Along the Road

Building community capacity, however, is not a linear process. In order to provide lasting support for very young children and their families, resources and infrastructure must be sustained over time. As discussed earlier, multi-year, multi-

faceted programs such as EHS experience fluctuating levels of community connections and an ebb and flow of relationships. Some efforts, ultimately, prove more successful than others—sometimes due to constraints imposed by timing or money. But the process of developing and sustaining community connections can also be affected by other issues, ones that are less obvious yet remain central to the likelihood of community change and program evolution. These are the broader issues of local community policies and philosophies.

One example of policy change that has affected EHS evolution involves an initial partnership with the Phoenix Union High School District. Program plans called for the district's South Mountain High School to serve as an EHS program site, thereby providing a school-based focus of services and activities for program parents. Through the South Mountain site, EHS expected to recruit a large number of high school-enrolled teen parents who would be continuing their education while learning to raise a family. By the end of the 1996-97 program year, however, the school district eliminated plans that would have provided adequate space for EHS activities and child care services—decisions that ultimately led to the closure of the South Mountain program site.

Loss of South Mountain as a base affected the overall program direction. Without an EHS program site on the South Mountain campus, far fewer of the recruited parents came from a school environment; and without the school as a focal point, program participation spread out geographically rather than concentrating in a defined neighborhood. As one administrator put it, losing the school focus felt like the program "lost its anchor." Another respondent said, if the program was to have an impact on the local community, it would need to be on a high school campus, have available child care, and be much more integrated into a specific neighborhood.

Another arena that has proven problematic is child care. As described earlier, EHS has had difficulty connecting parents with quality child care due to a shortage of appropriate services. While SWHD was able to provide a temporary solution for some EHS parents through agency management of the child care program at the Village charter school for teen parents, long-term child care solutions—for both EHS parents and the larger community—have been slow in coming.

In an attempt to mitigate this problem systemically, attempts are underway through SWHD initiatives to expand quality child care options via state-level legislation. Southwest Human Development is also pursuing the establishment of its own child care facility, and at the time of this report, agency administrators indicated they were moving closer to accomplishing this goal.

While challenges and obstacles that require course changes can be frustrating to program managers, they do not always imply failures or weaknesses. The implementation of programs such as Phoenix Early Head Start should, instead, be viewed as an evolutionary process, operating within the realities and constraints of "what is," while applying the lessons of experience. Furthermore, not all program obstacles are permanent. At the time of this report, EHS administrators anticipated a re-energized relationship with the Phoenix Union High School District. They also expected new or expanded relationships with the Village charter school, Crisis Nursery, and the Osborn School District. If these come to fruition, they hold the promise for collaborative activities that can better address the educational and child care needs of EHS families.

Taking Stock and Moving Forward

Returning to the original question regarding "community capacity," some answers have emerged. Based on an analysis of Phoenix Early Head Start experiences, building community capacity means a number of things. It means ensuring that people who work in early intervention programs receive relevant, comprehensive, early childhood development training to help them succeed at their task. It means helping those who work with young fathers to, first, view these fathers as integral to their children's lives and, second, focus fathers on accepting emotional and financial responsibility for their children. And it means informing the

community debate about teen parents—the challenges they face and the community support they need if they are to become the self-sufficient citizens that our society values. Ultimately, it means engaging and investing community decision-makers in the process of supporting children birth to three and their teen parents.

As EHS moves forward it must capitalize on its experiences and accumulated knowledge. This requires sustainable resources and infrastructure. It also requires that program administrators construct a bridge from their program experiences to broader policy actions, because supportive local and state policies are critical to making meaningful progress. Due to the availability of continued federal funding for Early Head Start programs, Phoenix Early Head Start program services will probably be supported beyond the current 5-year program cycle. And a bridge between experience and public policy appears to be underway through Southwest Human Development's leadership in the Smart Beginnings initiative, their active involvement in state-level discourse and advocacy regarding child care, and their influence in community discussions of child and adolescent health concerns.

In the long run, program leaders must stay on track with respect to the larger community agenda in order to have the greatest impact. Systemic changes and sustainable support to build capacity to address the needs of children birth to three and their families can occur only when appropriate public policies are put in place to advance it. The likelihood of success in this arena will increase when more decision-makers can connect the need for more support systems for young children and their families to public policy concerns regarding employment, education, self-sufficiency, and child support. Phoenix Early Head Start is in a unique position to help make that connection.

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Recommendations

Phoenix Early Head Start has made several course adjustments through the years as part of its focus on continuous program improvement. In response to one of last year's key recommendations, for example, program managers took decisive action to implement a more focused, cohesive training agenda for improving child development knowledge and skills among staff. Program managers have also begun to follow up on recommendations to deal proactively with the transition of children from infant to toddler, to develop standardized orientation for new employees, and to increase awareness of EHS in the service and policy arenas. Continued attention, however, is warranted in some of these areas. Based on analysis of evaluation data collected during the 1998-99 program year, the following recommendations are offered:

- ***Fortify strategies for helping parents understand and nurture their toddlers.***

Many EHS parents continue to face difficulties dealing with their children as they make the transition from infant to toddler. They have developmentally inappropriate expectations for their toddlers and use physical punishment as a discipline method. These problems signal the need for intensified program efforts aimed at helping parents understand this critical juncture in their child's development. EHS parents would benefit from more activities that provide information about age-typical behavior of toddlers and young preschool-age children, and more interventions that target misinterpretations of child noncompliance and offer developmentally appropriate strategies for addressing noncompliant behavior.

- ***Develop clear policies and practices for program transition.***

Parents and program staff have indicated they are unclear about the rules and regulations guiding transition of families out of EHS. Confusion centers around the specifics—the "who" and "when" of the transition process—and this has led to misinformation and frustration for both parents and family support specialists. Clear guidelines and a consistent message will ensure that transition procedures become equitable and timely for all program participants. The transition process for EHS families would also benefit from expanded alliances with appropriate Head Start/ preschool programs.

- ***Improve orientation procedures for new EHS staff, and establish mechanisms for retaining and rewarding long-term staff.***

High staff turnover has troubled EHS since its inception, creating a need for an orientation program that quickly brings new employees up to speed on basic program operations and values. In response to evaluation feedback, program managers have recently taken steps to bring a more focused and systematic approach to this problem. It is essential that this commitment be maintained so that EHS program values, goals, and procedures are clarified and operationalized for new family support specialists as they begin to work with families. EHS should also make an effort to reduce staff turnover by implementing a system of financial incentives and advancement opportunities that reward effective service. For a program that strives to develop supportive alliances with its families, it makes sense to hold onto the experience of proven staff.

- ***Implement solid strategies for communicating EHS knowledge and experience—and their implications for future public policy—to state and local decision-makers.***

Phoenix Early Head Start has served to some degree as a "laboratory" for determining methods that can assist children birth to three years old and their teen parents. To capitalize on this effort, the expertise and knowledge gained by the program must be made available, accessible, and understandable to people in state and local leadership positions. Program administrators can help move the community agenda for vulnerable young families forward by developing appropriate forums for disseminating EHS information.

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Appendix A

Phoenix Early Head Start Continuous Improvement Evaluation Plan

Desired Outcomes	Evaluation Questions	Data Sources/Measures
A. Family		
A1. Adult - Child Relationships Parents and other primary caregivers will develop positive adult-child relationships with the child, including: a. positive mother-child interaction b. positive father-child interaction c. effective parenting skills d. reduction of negative parenting behaviors	To what extent do EHS parents show evidence of positive adult-child relationships (including parenting skills)?	Raising a Baby/Raising a Child Parent-Child Activities Home Assessments Discipline Parent-Child Observations checklist
A2. Parent Mental Health Parents will exhibit indicators of positive mental health, including: a. using appropriate decision-making skills b. using effective coping skills in stressful situations c. not engaging in addictive behaviors (e.g., drug abuse, alcohol abuse, chronic gambling, eating disorders) d. demonstrating evidence of positive social interaction appropriate for their age	To what extent do EHS parents exhibit indicators of positive mental health?	Parenting Stress Index General Life Events Scale Coping Strategies Checklist Self-Efficacy Scale Self-Esteem Scale Program data
A3. Personal Health Care Practices Parents will exhibit recommended personal health care practices, including: a. obtaining appropriate prenatal, delivery, and postnatal care b. preventing unplanned pregnancies c. seeking appropriate medical care for routine and chronic health problems d. using preventive health care services	To what extent do EHS parents follow recommended personal health care practices?	Program data Case studies
A4. Educational Self-Sufficiency Parents will demonstrate progress in high school or higher education or job training programs appropriate to their individual goals	Do EHS parents participate in high school, higher education, or job training programs appropriate to their goals?	Program data Case studies

Desired Outcomes	Evaluation Questions	Data Sources/Measures
A5. Economic Self-Sufficiency Parents will make progress along a continuum toward economic self-sufficiency as evidenced by: a. progress toward outcome A4. b. employment status and earned income c. reduction in dependence upon subsidies and/or community emergency resources d. access to dependable and reliable transportation e. access to and use of quality infant-toddler child care for their child f. adequate housing g. using effective household management and budgeting skills h. literacy	Do EHS parents show evidence of progress along a continuum toward economic self-sufficiency ?	Program data Case studies
B. Infant-Toddler		
B1. Infant-Toddler Development Infants and toddlers (who do not have developmental delays or disabilities) will demonstrate age-appropriate development in all developmental areas including: a. cognitive development b. language and speech development c. social-emotional development d. physical (fine and gross motor) development	To what extent do infants and toddlers in the EHS program demonstrate positive developmental indicators (cognitive, language, social-emotional, physical)?	IDA Denver
B2. Developmental Delays or Disabilities Infants and toddlers who are identified with potential developmental delays or disabilities will be referred to and receive appropriate intervention services and will show progress in all developmental areas within the capacity of their ability.	Do infants and toddlers in the EHS program who are identified to have developmental delays or disabilities receive appropriate intervention services and show developmental progress?	Program data IDA Denver
B3. Healthy Parent-Child Relationship Infants and toddlers will show evidence of a healthy (i.e., developmentally appropriate) parent-child relationship including: a. responsiveness to parent(s) b. positive interactions with parents	To what extent do infants and toddlers in EHS show evidence of a healthy parent-child relationship?	IDA Parent-Child Activities Home Assessments Parent-Child Observations checklist

Desired Outcomes	Evaluation Questions	Data Sources/Measures
B4. Infant-Toddler Health Infants and toddlers will be healthy, as evidenced by: a. evidence of thriving (i.e., no non-organic failure to thrive) b. receive immunizations according to CDC periodicity schedule c. receive well-baby and well-child check-ups according to CDC periodicity schedule d. receive appropriate medical treatment for routine and chronic health problems e. receive additional developmental evaluations and related services if recommended f. live in a safe home environment that is free from hazards	Are infants and toddlers in the EHS program physically healthy?	Program data National Health Study: Safety
C. Staff		
C1. Supportive Alliances with Families Staff will acquire knowledge and demonstrate skills in establishing supportive and effective alliances with EHS families as evidenced by: a. non-threatening, sensitive, and ethical interactions b. empathic, genuine, and collaborative relationships c. sensitivity to families' culturally related values/issues	Did staff learn about and develop supportive alliances with EHS families?	Staff surveys Supervisor survey Videotape analysis Parent survey Focus groups
C2. Strategies for Adolescent Parents Staff will utilize appropriate strategies for working with adolescent parents and at-risk families that reflect an understanding of the importance of: a. developmentally appropriate goals and program activities b. a family systems perspective c. self-determination d. self-sufficiency e. risk and protective factors	Do staff understand and use intervention strategies appropriate for EHS parents?	Staff surveys Supervisor survey Videotape analysis Parent survey Focus groups

Desired Outcomes	Evaluation Questions	Data Sources/Measures
C3. Child Development and Parent-Child Relationships Staff will acquire knowledge and demonstrate skills in working with families on early child development and parent-child relationships including: a. infant-toddler development b. attachment c. positive parent-child interaction d. the role of young fathers	Do staff understand and help EHS parents develop positive adult-child relationships (including parenting skills and parent-child interactions)?	Staff surveys Supervisor survey Videotape analysis Parent survey
C4. "Core" Knowledge Staff will acquire "core" knowledge essential for implementing the Phoenix Early Head Start program including: a. adolescent development b. adolescent health/mental health c. perinatal care d. family planning e. well-child care f. community-based resources g. child care	Did staff acquire the core knowledge necessary to implement EHS program services?	Staff surveys
D. Community		
D1. Phoenix Early Head Start will facilitate the development of parent/child support services including: a. child care b. health services c. education	To what extent were support services established?	Program documentation
D2. Phoenix Early Head Start will establish cooperative relationships with community service providers and provide coordinated services to program participants.	To what extent were cooperative efforts with community service providers implemented?	Documentation of the collaborative process Survey, interview, and observation data
E. Policy		
E1. State and local policy makers will become aware of the benefits of Early Head Start and support policies that address the needs of pregnant and parenting teens and their young children.	Are state and local policy makers knowledgeable about the benefits of the Early Head Start program? To what extent does knowledge gained from the Early Head Start program influence policy makers in their decision-making related to teen parents and their young children?	Documentation of efforts to communicate Early Head Start program results to state and local policy makers (e.g., meetings, briefings) Survey of selected state and local policy makers

Appendix B

Summary of Data Collection Instruments And Methodological Notes

Findings were reported only for those correlations that were statistically significant at probability < .05.

Data analyses do not include special needs families—with three exceptions. Special needs families are included in the Public Assistance Snapshot, the Profile of Families with Inadequate Resources, and the General Life Events data.

Data analyses are based on all participants for whom data were available regardless of whether or not some of these participants subsequently disenrolled from the program.

The participant assessment instruments described below are included in the Phoenix Early Head Start Enrollment Assessment and the six month, 12 month, 18 month, 24 month, and 30 month assessments.

Raising a Baby/Raising a Child, Safety, Parent-Child Activities, Parenting Stress Index and the Home Assessment were adapted from the national *EHS 14 Month Parent Interview* and *Interview for Parents of Two Year Old Children*.

Self-esteem was measured with an adapted form of Rosenberg's 10-item *Self-Esteem Scale* (1965). Participants are asked whether they strongly agree, agree, disagree or strongly disagree with a variety of both positive and negative statements. Item responses combine to yield a seven-point scale. Scores range from 0 to 6, with low scores indicating high self-esteem and high scores indicating poor self-esteem.

Self-Efficacy Scale is based on Pearlin's *Mastery Model* (1981) and measures the extent to which an individual views their life circumstances as within their own control. The scale is comprised of seven statements, with which participants indicate whether they strongly agree, agree, disagree, or strongly disagree. The self-efficacy score is calculated by taking the average of the item responses, with reversed weights for positive statements. Scores range from 1 (low self-efficacy) to 4 (high self-efficacy).

General Life Events is a shortened version of the *General Life Events Schedule for Children* (Sandler, Reynolds, & Ramirez, 1986). On this measure participants are asked to indicate which of the 20 stressful life events presented have occurred in their lives in the past month. The score is equal to the total number of "yes" responses given.

Coping Strategies is a measure composed of 24 items taken from the *Children's Coping Strategies Checklist* (Preventive Intervention Research Center, Arizona State University, 1992). These items represent different types of positive strategies that young people can use to deal with stressful life situations. For each statement, participants are asked to choose among four responses to best describe how often they have used each strategy to deal with their problems in the past month (never, sometimes, often, and most of the time). The average of all responses is calculated to find the score. Scores range from 1 (infrequent use of positive coping strategies) to 4 (very frequent use of positive coping strategies).

Raising a Baby/Raising a Child are, respectively, nine-item and 13-item scales adapted from the Knowledge of Infant Development Inventory (McPhee, 1981). Items assess participants' knowledge of infant/toddler norms and milestones, developmental processes, and caregiving strategies. The total score on these scales is comprised of the total number of correct responses.

Parenting Stress Index (PSI) is an abbreviated version of an instrument developed by Abidin (1995) which presents 13 statements that reflect parental distress and dysfunctional parent-child interaction. Parents are asked how much they agree with each statement (strongly agree, agree, disagree, strongly disagree). Scores on the PSI are calculated by reversing the weights for all items and calculating their average. Possible scores range from 1 (low parenting stress) to 5 (high parenting stress).

Safety is evaluated by assessing parents' knowledge of safety precautions. Participants are asked a number of questions from the *Early Head Start 14 Month Parent Interview*. Questions address the use of smoke alarms, car seats, and covers for electrical outlets, as well as participants' knowledge of what to do if their child swallows something poisonous.

Home Assessment: These questions were adapted from the Infant/Toddler form of the Home Inventory. For the purposes of this evaluation, a summary score is calculated for ten items designed to assess parents' contacts and interactions with their child. Three items are based on parent responses and seven items are based on interviewer observations. Interviewers code their observations after completing the visit.

Infant/Toddler Home Inventory assesses the quality of stimulation found in the early home environment. The instrument contains 45 items composing six aspects of home environment: emotional and verbal responsivity of mother; avoidance of restriction and punishment; organization of physical and temporal environment; provision of appropriate play materials; maternal involvement with child; and opportunities for variety in daily stimulation. An item receives a plus (+) if the behavior is observed during the home visit or if the parent reports that the condition or event described is characteristic of the home environment, with a total possible score of 45.

Parent-Child Activities is a tool designed to provide information about the types and frequencies of parent-child activities. Items draw upon parents' encouragement of language development, routine activities, and experiences outside the house. Parents are presented with age-appropriate parent-child activities and asked how often they engaged in each activity with their children (ranging from "more than once a day" to "a few times a month" to "not at all"). Five items focus on activities between the primary caregiver and the child. If the child's other biological parent is also involved in the child's life, the primary caregiver responds to five additional items about the child's activities with that parent.

Parent-Child Observations Checklist is a locally developed instrument designed to elicit the family support specialist's perceptions of the quality of parent-child interactions, based on their observations over a six-month period. Family support specialists are asked their level of agreement (from "strongly agree" to "strongly disagree") with ten items describing specific aspects of parent-child relationships. The average of all responses is calculated to produce a score. Possible scores range from 1 (lower quality interactions) to 5 (higher quality interactions). In addition, family support specialists are asked to rate the overall parent-child relationship and to characterize its overall emotional tone.

Infant-Toddler Developmental Assessment (IDA), Provence Birth-to-Three Developmental Profile, uses observation by professional practitioners and parental report to assess the child's development in eight domains. For the purposes of this evaluation, a "developmental risk score" was created by summing across the domains of: gross motor, fine motor, relationships to inanimate objects, language/communication, self-help, and social/emotional (a composite of relationships to persons, emotions and feeling states, and coping behavior). Only scores for competent functioning were included; therefore, a higher score indicates higher functioning.

Denver II is a 1990 revision of the Denver Developmental Screening Test. The Denver is widely used to detect potential developmental problems in infants and young children by comparing the child's performance on a variety of tasks to performance norms. The tasks are arranged in four sections: Personal-Social, Fine Motor Adaptive, Language, and Gross Motor.

Parent Survey is administered annually and is designed to elicit information directly related to EHS program services. Respondents are asked their level of agreement (from "strongly agree" to "strongly disagree") with 18 statements about different aspects of their relationship with their family support specialist. The survey also includes two open-ended questions about the program in general.

Staff Video-clip Analysis is a locally developed instrument designed to assess the extent to which family support specialists can implement what they learn with families. They viewed two video-clips: a mother with her 11-month-old child, and a mother with her 24-month-old-child. For two domains—child development and parent-child relationships—the family support specialist identifies critical strengths and critical concerns. Responses are compared to an answer key developed by an ad hoc EHS evaluation group. Two scores are calculated for each video-clip: 1) exemplar score—the number of correctly identified examples of a concept, 2) conceptual score—the number of correctly identified concepts underlying an exemplar.

Staff Knowledge Assessment is a local instrument that asks questions about concepts presented during a SWHD Child Development Course. Family support specialists are asked to respond to a variety of short-answer questions.

Staff Surveys provide information about staff's self-assessment of their knowledge and training. Family support specialists are asked to rate (extensive, moderate, barely adequate, inadequate) their knowledge of and/or training on 40 topics. They are also asked their level of agreement (from "strongly agree" to "strongly disagree") with 13 statements related to EHS program "values" and practices.

Focus Groups are small discussion groups designed to obtain information about the perspectives of project participants and stakeholders regarding the EHS program. An interview protocol consisting of 6 to 10 open-ended questions is developed for each group. Participants are encouraged to engage in an exchange of ideas and explore various aspects of the project in depth.

Appendix C

Stressful Life Events—At 24 Months in Program

Event	Percent of Occurrence*
One of your brothers/sisters was very angry or upset	53.7%
Your parent(s) acted very worried, upset or sad (not because of anything you did)	48.8%
Your mom/dad talked about having serious money troubles	48.8%
You saw your mom/dad drunk	37.2%
A close family member or someone you live with committed a crime, got in trouble with the law, or was sent to jail	30.2%
Your brother/sister had serious trouble (with the law, school, drugs, etc.)	29.3%
Your relatives said bad things about your parent(s)	28.6%
Your close friend had serious troubles, problems, illness or injury	26.2%
Your mom/dad suffered from serious illness or injury (requiring hospitalization or at least one week in bed)	25.6%
Your mom/dad forgot to do important things for you that they promised they would do (such as take you on a trip, take you to nice places or come to your school or athletic event)	23.3%
A close family member died	20.9%
Your mom/dad fought or argued with your relatives (aunts, uncles, grandparents)	19.0%
People in your family physically hit each other or hurt each other (parents, brothers/sisters)	16.3%
You suffered from a serious physical illness or injury (requiring bed rest for one week or more, hospitalization, any surgery or being in extreme pain)	14.0%
Your parent(s) acted badly in front of your friends (yelled at them, criticized them, or was drunk in front of them	14.0%
A close friend died	11.6%
A close friend of yours moved away	9.5%
Your brother or sister suffered from a serious illness or injury (requiring bed rest for one week or more, hospitalization, any surgery or being in extreme pain)	7.3%
One of your parents lost their job	7.0%
People in your neighborhood said bad things about your parent(s)	2.4%

*Event occurred during the prior month

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